The MODERN HOSPITAL

Vol. XLI SEPTEMBER, 1933 No. 3

1883

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ANNIVERSARY

1933

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For September, 1933

Just in Passing—

THIS issue marks the beginning of the third decade of publication of The MODERN HOSPITAL. It is particularly gratifying to those associated with the magazine that, as it starts this new decade, there are increasing signs of relief to overburdened hospitals. Better feeling generally, combined with tangible evidences of a business upturn, are already making themselves felt in the hospital field.

Plans for essential building projects are being removed from the shelf, dusted off and laid again on the directors' table for consideration, revision and future action. Rehabilitation and modernization programs are taking shape, prompted by increased demands for certain types of service. Finances are being studied and definite steps are being taken to make up deficits incurred during the past months. There is a distinct disposition on the part of hospital executives and trustees to make a new start, with fresh hope for the future. That the hospital has a new opportunity and a new responsibility as it comes out of the depression is pointed out in the leading editorial on page 94.

IN THIS new order of things, The MODERN HOSPITAL is better prepared than ever before to render service to the hospital field. Its expanded editorial service will maintain closer contact with large and small hospitals. The editors invite readers to "think aloud" with them through the mails. Particularly now when events are moving with such speed they would welcome comment and suggestion.

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CONTENTS

THE possible direct effects on hospitals of the National Industrial Recovery Act have been the subject of much discussion among hospital people during the last month. Apparently the question is now authoritatively settled. Donald R. Richberg, counsel for the National Recovery Administration, has ruled that charitable nonprofit hospitals are not required to come under the provisions of the act. The ruling is given in full on page 128.

SEPTEMBER and October are the national convention months in the hospital field. The American Hospital Association, the Protestant Hospital Association, the American College of Surgeons' hospital standardization conference and other meetings of smaller groups are featured in this issue beginning on page 101.

With the conventions, Hospital Day at A Century of Progress and the Institute of Hospital Administrators drawing hospital people to Chicago and the Lake Michigan region, The MODERN HOSPITAL repeats its standing invitation to all hospital administrators to visit the office when in Chicago.

A NEW feature appears in the dietetic department of the magazine this month. The offering is a menu a day. A similar page will appear regularly each month for a year and it is hoped that dietitians will find the menus listed there of signal service as a basis for planning meals for the general hospital patient.

IF YOU haven't already made plans to attend Hospital Day at the World's Fair, better reach for your engagement book now. September 16 is going to be a big day for the hospital world. Not only will special arrangements be made to help you see the things of particular hospital interest at A Century of Progress, but the service of hospitals will be forcefully brought to the attention of the public. Hospital people will gather briefly at 10 a.m. in the Hall of Science. A special luncheon at 1:00 p.m.

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Vitavose
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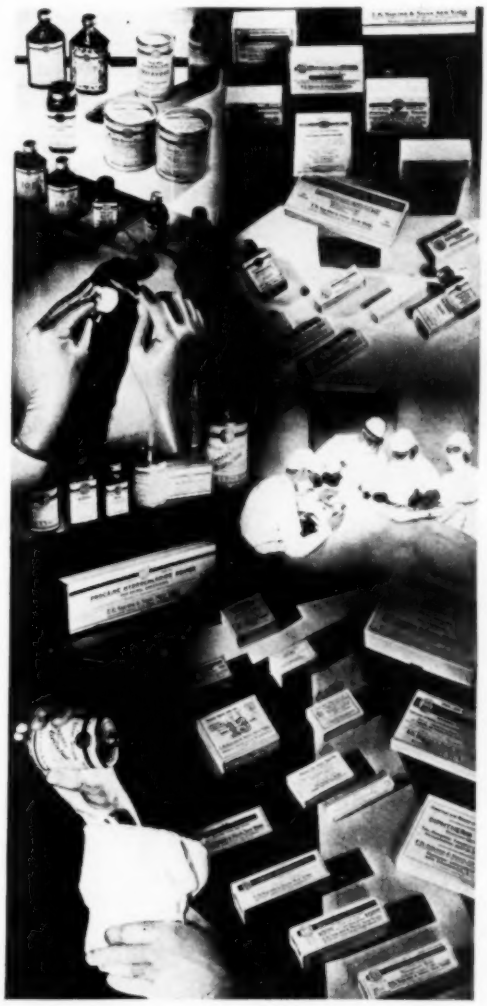

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We cordially invite you to visit the Squibb Exhibit at Booths 49 and 72 at the American Hospital Association Convention in the Milwaukee Auditorium from September 11th to 15th. Squibb representatives will be in attendance to discuss and answer questions regarding Squibb Products for hospital use.

When you visit the Century of Progress Exposition in Chicago don't fail to see the Squibb Exhibit on the ground floor of the Hall of Science.

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

will be held at the Pabst Blue Ribbon Casino. Following luncheon a style show will be staged for those who wish to see it. At 8:00 p.m. a large public meeting will be held in the court of the Hall of Science. Several thousand Chicago nurses will attend in uniform. Paul Fesler, president, Chicago Hospital Association, will be master of ceremonies, and N. S. Faxon and Dr. Malcolm T. MacEachern will speak.

FLASHES FROM THIS ISSUE:

"Members of the medical staff should not gossip." *Page* 46.

"The mere act of recording an unsatisfactory result for a day or a month serves as a real incentive to the manager of a supplementary department to improve his own performance." *Page* 51.

"If nursing education has failed, it is not because of the apprenticeship system, but because of improper application of the principles of apprenticeship." *Page* 57.

"The hospital that teaches its personnel to practice an unfaltering aseptic technique teaches a mode of living that will yield big dividends in health throughout the lives of these individuals." *Page* 67.

"A review of thousands of individual hospital accounts causes a hospital executive to change his point of view. He sees operating room and x-ray fees in the same light as the patient." *Page* 73.

"The use of color to brighten corridors and make windowless rooms pleasant is one of the outstanding features of the hospital." *Page* 80.

"The record room clerk must have the courage of her convictions. She must never be tempted to seek the easiest way by burying incomplete and inaccurate charts in the files without making an effort to correct the omissions and mistakes." *Page* 91.

"Every sterilizing room should have over its door the old adage: 'Better safe than sorry.'" *Page* 114.

"To avoid arguments, to prevent favoritism, to ensure a well conducted department, every employee should have a clear understanding of his or her duties under normal conditions as well as in emergencies." *Page* 122.

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.
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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOL. XLI *September, 1933* NUMBER 3

A Code of Ethics for Hospital Physicians

By MALCOLM T. MACEACHERN, M.D.
Director of Hospital Activities, American College of Surgeons, Chicago

ETHICS may be defined as a "science of duty or morality." A code of ethics for hospital physicians would necessarily include all the principles laid down by the American Medical Association for the general practice of medicine. But it is more than that. The hospital is more and more becoming the workshop of the physician and surgeon, and in that environment there are new relationships to be considered. There are relations with the superintendent, residents, interns, nurses, dietitians, pathologists, radiologists, and all the other personnel engaged in the hospital's work of caring for the patient. Such a code of hospital ethics, while greatly needed, has never been promulgated.

It is in the hospital that the young doctor can early become acquainted with ethical procedure. Obviously, the amount of information pertaining to ethics which the medical student receives before completing his course varies to a considerable degree in different medical schools. It is generally scanty. At best, it is only theoretical.

While there is no written code available, the principles involved are generally understood. Therefore, this discussion will merely attempt to assemble these principles in a practicable manner. In such a compilation certain details may justifiably be disregarded.

The code must include five major principles:

1. The resident staff and the visiting staff must be ethical in relations among themselves.

2. Interns and residents must conduct themselves ethically in relation to the visiting staff, and in turn should be treated ethically by the visiting staff.

3. The relations of interns, residents and visiting staff to patients must always be strictly ethical.

4. Interns, residents and visiting staff are held responsible for ethical conduct to the hospital management and personnel.

5. The resident and visiting staffs in upholding the honorable reputation of their profession must be strictly ethical in their relations with the public.

Principle No. 1. The resident staff and the visiting staff must be ethical in relations among themselves.

The "Principles of Medical Ethics" of the Americal Medical Association are, of course, applicable to interns, residents and physicians working in the hospital. According to this code, it is incumbent upon a physician to uphold the honor of his profession by comporting himself as a gentleman. He should refuse to allow men deficient in "moral character or education" to join the profession, and should "expose without fear or favor, before the proper medical or legal tribunals, corrupt or dis-

honest conduct of any members of the profession."

Ethical physicians do not treat themselves or their own families. They willingly give gratuitous professional service to a brother physician or his immediate family.

Physicians must never be insincere with one another, and should at no time evidence rivalry or envy. Especially must this be remembered during consultations. A consulting physician should be punctual and tactful. When the attending doctor is absent during an emergency, a consultant may take charge until the attending physician returns, but he can do no more than provide for the emergency unless he has the consent of the physician in charge.

Splitting of Fees Is Unethical

A physician may not make a social call upon the patient of another physician without having the consent of the latter. When a physician succeeds another in a case, he must not criticize the conduct of the practitioner who preceded him.

The doctor who arrives first when several have been summoned is considered to be in charge of the case. But he should subsequently withdraw in favor of the family physician or the one desired by the patient.

"When, because of a sudden illness or accident, a patient is taken to a hospital, the patient should be returned to the care of his known family physician as soon as the condition of the patient and the circumstances of the case warrant this transfer."

When a physician treats a patient at the request of a colleague, he should care for him in exactly the same manner that he would want his colleague to treat his patient in a similar instance. On the return of the attending physician, a patient is always relinquished.

"Whenever there arises between physicians a grave difference of opinion which cannot be promptly adjusted, the dispute should be referred for arbitration to a committee of impartial physicians."

Splitting of fees or giving commissions, under any conditions, no matter whether for consultation or treatment, is extremely unethical.

The best evidence of good ethical conduct is demonstrated through the sincere interest of the individual physician in the welfare of his fellow practitioner. Such interest is characterized by unselfishness, kindliness and good intent.

Principle No. 2. Interns and residents must conduct themselves ethically in relation to the visiting staff, and in turn should be treated ethically by the visiting staff.

This principle differs from the first one in that it is a distinctly hospital relation. It considers the two-sided relationship of teacher and pupil, in which the physician is looked upon as the teacher, and the intern as the student. Each must govern himself accordingly. To the teacher, the student owes respect and obedience. To the student, the teacher owes kindliness and consideration. Upon their conduct individually and to each other depends not only the ethical reputation of the profession, but also the quality of care given to their patients.

The ethical conduct of interns and residents should develop as a natural result from their earliest contacts with the visiting staff. Such proper behavior must develop by precedent and example, however.

First of all, interns and residents should be thoroughly obedient and promptly responsive to their senior's wishes. Although they are engaged by the hospital and actually serve the institution, interns and residents must remember that they are also directly responsible to the medical staff, which includes every physician and surgeon working in the hospital.

The orders of attending physicians must be carried out with prompt, courteous and honest response. At no time should the intern or resident assume too much responsibility in the care of the patient without communicating with his superior officer. In fact, methods of treatment outside the routine should not be initiated by the intern or resident without first consulting his chief officer. Orders of the attending physician must not be changed by the resident staff without his approval. Interns and residents must at all times address their superior officers with respect and courtesy.

Members of the resident staff should not gossip. They must not criticize the attending physician nor complain about his treatment except to the physician himself. If the intern is not satisfied with his treatment by the attending physician, he must take up the matter with the physician himself.

The Patient Must Come First

In case the intern or resident feels that he cannot conscientiously participate in the treatment recommended, it is proper for him to lay his case before the superintendent and the intern committee.

There are times when the intern or resident may be expected to work overtime, or delay meals and recreation. Such personal inconveniences must be subordinated to the interests of the patient, and should be borne in a kindly and cooperative spirit.

Ethical conduct must also operate in the reverse direction. The attending physician is duty bound to treat his subordinates considerately. He must not forget that the intern expects him to be ex-

emplary of the best ethics of the medical profession, as followed by the experienced practitioner outside the institution, among his confreres and in medical organizations.

Physicians must not forget that they teach not only by what they do, but also by what they say. The loud talking, belligerent attending physician sets a bad example for the young residents. Likewise, the physician or surgeon given to profanity and abusiveness has a deleterious effect on all those training in the hospital. It is impossible for the visiting physician who treats his diagnosis and therapy in a hasty, superficial fashion to impress the intern with the value of scientific medicine.

Commercial or fee splitting surgeons disseminate the worst kind of influence on young graduates. Social engagements should be indulged in outside of hospital activities. The ethical relationship between the visiting staff and the resident staff in the hospital should be entirely one of professional and scientific cooperation.

Is Duty Bound to Respond to an Emergency

Principle No. 3. The relations of interns, residents, and visiting staff to patients must always be strictly ethical.

The resident and visiting staffs can properly control their ethical relations to the patient by measuring their conduct in terms of the best care of the patient. On this point the code of ethics promulgated by the American Medical Association states: First of all, "reward or financial gain" is subordinated by the ethical physician to service to humanity. The physician must conduct himself with "patience, delicacy and secrecy." In order to serve the best interests of the patient and his family, the physician must be confident that the patient's condition is known by the patient or his friends. Although a physician can choose his own patients, he is duty bound to respond to an emergency. He cannot neglect a case once he has accepted it, nor abandon the patient because he is suffering from an incurable disease or for any other reason. Only when the patient has secured other medical attention and has released the first physician is he free to leave the case.

Physicians should never discuss matters pertaining to the patient's condition in the presence of the patient, other than the most casual reference regarding his condition or favorable and encouraging comment.

Nothing should emanate from the visiting or resident staff which would in any way reduce the confidence of the patient in the attending physician or in the hospital. If the patient is dissatisfied with the visiting physician and desires a change, it is within the province of the superintendent to negotiate such a change, but in so doing the following considerations must be given to the case: The patient should notify the attending physician that he desires a change in attending doctors; if this information is given to the intern or resident, he should convey it privately to the superintendent, advising the patient, however, to take up the matter with his own doctor. Before another physician is admitted to see the patient, it should be thoroughly understood that the former doctor has been properly released from the case.

Frequently, the superintendent will be obliged to negotiate the entire transfer, but the matter is sometimes satisfactorily settled through the negotiations of patients and doctors.

All information pertaining to the patient should be kept confidential by the resident staff. The resident staff should engage in such discussions only on properly arranged occasions, as, for instance, when the scientific aspect of the work is involved. Gossiping about patients is as unethical as gossiping about physicians. The entire staff, both resident and visiting, must regard all such matters as strictly confidential.

At no time should the intern or resident seek remuneration from the patient for services rendered. If money or gifts are offered, the matter should be reported to the superintendent who will advise as to the proper course to pursue.

The attitude of interns, residents and physicians toward the patient should be altogether professional and should cultivate in the patient a greater confidence in the institution and in scientific medicine. They must never develop a familiarity which might be misunderstood, and therefore should refrain from conveying to the patient news of what occurs in the hospital, particularly in regard to deaths or other untoward results.

Superintendent Is Superior Officer

Principle No. 4. Interns, residents and visiting staff are held responsible for ethical conduct to the hospital management and personnel.

That interns and residents should be ethical in their behavior to the hospital management and personnel is important not only because they are employed by the institution, but also because it is through proper cooperation and willingness to subordinate all selfish interests that the maximum service can be afforded to patients.

The intern or resident must realize upon assuming his position in the hospital that he is responsible to the administration for his conduct, and that he is expected to render faithful service in the discharge of his duties. The superintendent in particular is his chief superior officer in relation to the administrative aspect of the institution he

serves. Therefore, the superintendent expects strict obedience, prompt response to orders, honest action and unselfish service at all times. The intern and resident must be prepared to obey thoroughly the rules and regulations set forth for their conduct which prohibit such actions as might be considered vulgar or disorderly.

Members of the resident staff should hold themselves duty bound to report to the superintendent any conditions which they believe are not to the best interests of the patient or the institution. They should feel that the hospital is their home, and should willingly exercise the utmost care at all times to conserve equipment and supplies.

Must Cooperate With Other Employees

The fact has been mentioned that the attitude of interns and residents toward the superintendent and management should be one of respect and courtesy; the same attitude should be evidenced by the visiting staff. Here, too, destructive criticism or gossip should never be tolerated, and when there are controversies, misunderstandings or disagreements, there should be a prompt meeting of the participants in order to bring about closer unity of thought.

In their routine, both the resident and visiting staff must work closely with many other hospital employees, particularly the professional personnel —nurses, dietitians, social workers and technicians. In this relation a strictly professional attitude must be maintained, which, although courteous, is free from anything that might be interpreted as familiarity or undignified conduct.

Physicians as well as resident staff members must recognize and respect the proficiency of other groups of workers in the hospital. They must realize that these groups represent specialties and are as thoroughly skilled in their respective duties as is the physician in his.

Principle No. 5. The resident and visiting staffs in upholding the honor of their profession must be strictly ethical in their relations with the public.

The final chapter in the American Medical Association's "Principles of Medical Ethics" states clearly what the conduct of the medical profession should be in relation to the public. According to the code, physicians should warn the public concerning the "devices practiced and the false pretenses made by charlatans which may cause injury to health and loss of life." In addition, pharmacists who are unqualified or who dispense unsuitable drugs should not be countenanced by the medical profession.

Physicians should "advance the interest of humanity" and as good citizens should "cooperate especially with the proper authorities in the administration of sanitary laws and regulations. They should be ready to counsel the public on subjects relating to sanitary police, public hygiene and legal medicine.

"Physicians, especially those engaged in public health work, should enlighten the public regarding quarantine regulations; on the location, arrangement and dietaries of hospitals, asylums, schools, prisons and similar institutions, and concerning measures for the prevention of epidemic and contagious diseases. A physician must continue his labors for the alleviation of suffering people when an epidemic prevails, without regard to the risk of his own health or life or to financial return. At all times, it is the duty of the physician to notify the properly constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities."

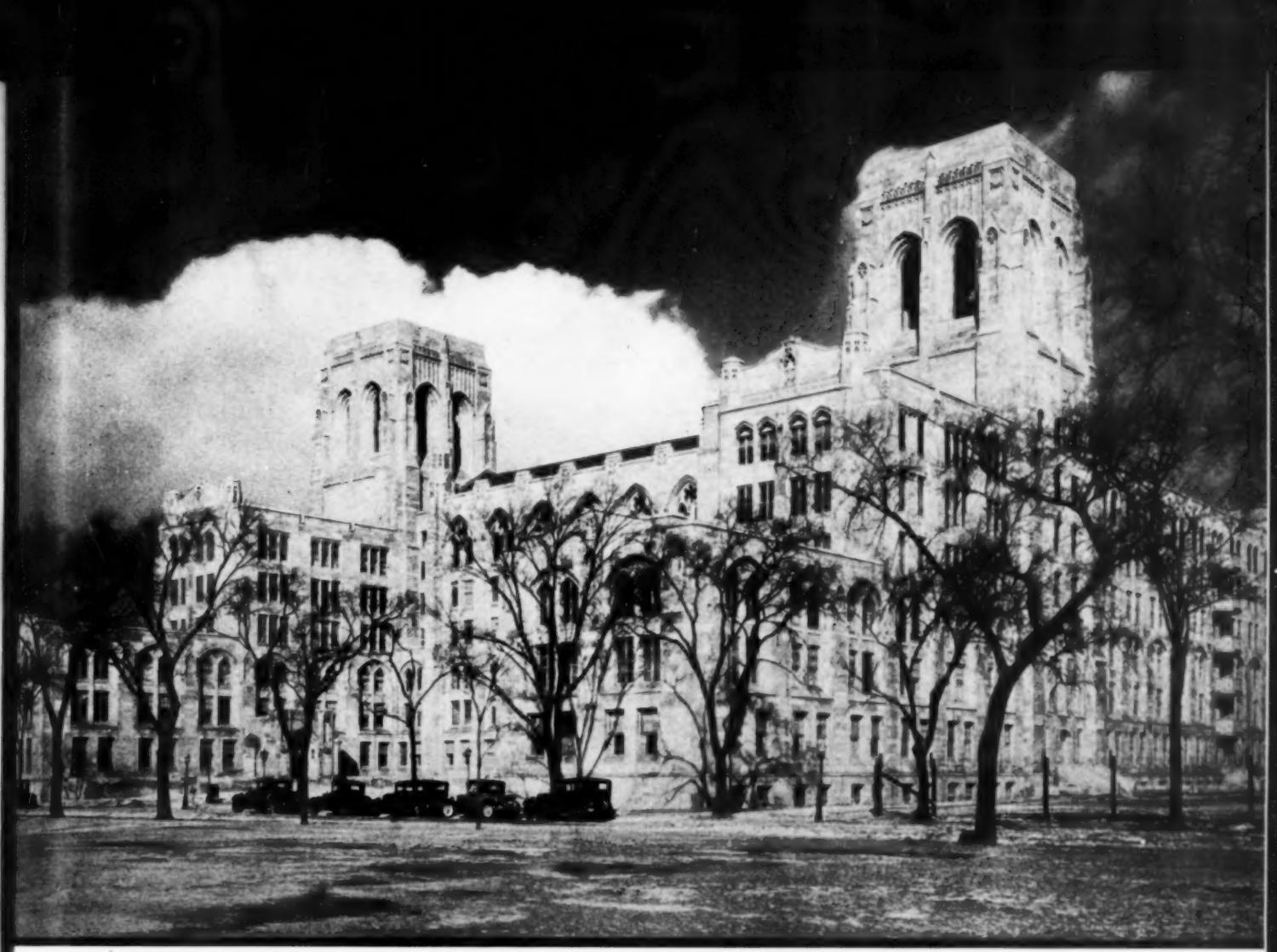
Interns and residents must treat the layman with respect, giving him in a discreet manner the information he desires about patients or other matters which are considered safe to discuss. All information given the public must be carefully guarded so as not to disclose confidential information concerning the patient. Nevertheless, Mr. Citizen must not be made to feel that the hospital is secretive or hiding information which in all fairness is the property of the public.

In this respect, it might be wise to mention a matter that involves a careful exercise of hospital ethics—the newspaper. Hospitals are a fertile source of news. Now with the splendid growth of a public relations service in many institutions, it can be expected that the contacts between hospitals and newspapers will be even more frequent.

Superintendent Should Control Publicity

If physicians are requested to make statements concerning the hospital or particular cases within the hospital, they must remember that it is unprofessional and unethical to provide "newspaper or magazine comments concerning cases in which the physician has been or is concerned." All comments regarding the hospital and patients treated within the institution should emanate from the superintendent's office. In giving out any such information it is always advisable to omit the name of the physician.

While it is hoped that these suggestions may act as a stimulus in encouraging hospitals to formulate a code of ethics for their physicians, I should like to emphasize the fact that it is not the codification but the practice of these principles that is important. However, a code is invaluable as a guide, and is most effective in accomplishing the universal practice of proper conduct.



Financial Control System Ensures Economy at U. of C. Clinics

By JOHN C. DINSMORE
Superintendent, University of Chicago Clinics

THE basic theory back of the financial control of the University of Chicago Clinics rests upon two simple principles:

a. The breaking down of the whole project into a number of small control units each under a competent department head and each having an income and expense budget and a production bogey.

b. The careful application of the principle that if each department lives within its budget and meets it production bogey each day, the financial results for the project will be satisfactory each day; and if each day's results are satisfactory, the monthly and yearly results will be satisfactory.

The breakdown into control units follows:

1. Billings Hospital (228 beds) and Bobs Roberts Hospital (80 beds) are considered as one administrative unit with a separate income and expense budget and a separate space on the daily report. When either the income or expense figures are unsatisfactory, this unit may be broken up into thirteen smaller administrative hospital units for special study purposes. The expense budget is controlled under thirty-seven separate headings.

2. The Hicks and McElwee Hospitals for orthopedic children (50 beds each), which are operated by and for the Home of Destitute Crippled Children, are a separate administrative unit with a separate board. This unit has its own investment funds and a separate budget of income and expense. The expense budget is controlled under thirty separate headings.

3. The clinic of the Home for Destitute Crippled Children on the west side of Chicago has its separate income and expense budget which gives control

Simplicity and unity of design characterize the group of buildings that constitute the University of Chicago Clinics. The massive square towers rise to a height of twelve stories, giving dignity to the setting.

	Today	To Date This Month	To Date Last Month	This Date Last Year
HOSPITAL INCOME				
Budget Pro Rata				
Over or *Under Budget				
OUT PATIENT INCOME				
Budget Pro Rata				
Over or *Under Budget				
SUPPLEMENTARY DEPARTMENTS				
Operating Room				
Physio-therapy				
Electrocardiograph				
Radium				
Basal Metabolism				
Glasses				
Braces				
Plaster Room				
Pharmacy				
TOTAL				
Budget Pro Rata				
Over or *Under Budget				
PROFESSIONAL SERVICES				
X-RAY AND X-RAY THERAPY				
SUMMARY				
Opening Balance				
Add, Charges				
Total				
Less Collections				
Leaving				
Less, Charge-offs				
Closing Balance				

PHOTOGRAPHIC SHOP
Back Log _____
Billings to date _____
Total billings so far this month _____
Total billings this time last month _____
FOOD SERVICE DEPARTMENT
Cash Income today _____
Cash Income so far this month _____
Cash Income this time last month _____

Total Income today _____
Total Income so far this month _____
Total Income this time last month _____

The daily income report.

under fourteen separate and distinct headings.

4. The Country Home for Convalescent Children (120 beds), at Prince Crossing, Ill., about forty miles west of Chicago is broken up into two major control units: the home proper, including the Raymond Hospital, and the farm. Each unit has its separate but carefully integrated budget under forty-nine separate headings.

5. The Chicago Lying-in Hospital, an affiliated institution with 162 beds and 150 bassinets, has not only its own income and expense budgets, but is also controlled by a separate board. Its endowment funds are held separately. The income is controlled under eighteen separate headings and the expense budget under forty-five.

6. The Stock Yards Dispensary of the Chicago Lying-in Hospital has its separate income budget under three separate headings and its expense budget is controlled under eleven separate headings.

7. The Home Service Unit of the Chicago Lying-in Hospital has just been set up and will have a separate income and expense budget.

8. The Max Epstein Clinic, in the main building with a branch in the Chicago Lying-in Hospital, has its own income and expense control under thirty-seven separate headings.

In addition to the above units which are primarily concerned with the care of patients there are sixteen supplementary service units which are in effect operated as separate small businesses. They are: operating room; physiotherapy; electrocardiograph; radium; basal metabolism; glasses; braces; occupational therapy; plaster room; retail pharmacy; manufacturing pharmacy; food service department; general stores; stationery stores; animal floor; photographic division.

This arrangement makes the administration of the University of Chicago Clinics responsible for a total of 690 beds and 150 bassinets, and for three outlying clinics, owned and operated by four separate boards. Since the administration is centered in the offices of the director and the superintendent of the University of Chicago Clinics it makes it possible to set up and carry out a unified financial policy for the whole group. This financial policy simply stated is the fixed determination not to make any financial commitments of any kind until the money to pay for these commitments is in hand.

Each operating unit has a budget conservatively drawn, and every monthly expenditure is charged to the proper budget item. At the beginning of each budget period a large control sheet is set up for each unit.

On the left-hand side of this sheet are set up the various items of income and the various items of expense in the order in which they appear in the budget. Across the top of the sheet from left to right are tabulated the following data: (a) total amount budgeted for the year; (b) monthly pro rata; (c) actual expense for the month; (d) the amount over or under the estimate. At the end of each quarter a total of each item of income and expense for the quarter is taken together with the total amount over or under the budget.

Daily Report Also Used

This method gives the superintendent of the clinics a complete picture of the condition of each income and expense account at the end of each month. This gives control after the income has been realized and before the expense is incurred. By consulting these control sheets before any unusual item of expense is incurred the administration gets control before the fact. This device is adequate for the control of the smaller units. For the larger units involving more expense and requiring a more careful check, an additional daily report form is used. This report is made up by the night bookkeeper and is placed on the desk of the superintendent before seven o'clock each morning. The form of daily report used for the university clinics and for the Chicago Lying-in Hospital is shown here.

It is said that the only justification for making a record is that it may serve as a guide to future conduct. Measured by this yardstick these records more than justify their continued existence. The monthly control sheets are consulted constantly before expenses are incurred. The daily report sheet is studied each morning before the superin-

tendent keeps any appointments. Wrong or financially dangerous tendencies, as shown by the daily report sheets, are studied in detail and corrected.

In addition to the data given in the daily report, the head of each supplementary department is encouraged to keep his own daily records of income and expense so that he may more intelligently control the management of his own department.

The managers of supplementary departments that are not going well are required to send daily to the superintendent of the clinics a more detailed statement showing total salary cost, total other expense, total overhead and total cost for the day, together with total earned income and total surplus or deficit. The mere act of recording an unsatisfactory result for a day or a month serves as a real incentive to the manager of a supplementary department to make improvement on his own performance.

Cost Accounting Emphasized

In the matter of cost accounting, and cost studies, the University of Chicago Clinics have gone further than other similar institutions. It is necessary to keep the books on three different bases: (1) cash—because income is available only when received; (2) cumulative—because a large volume of accounts receivable is carried and because many expenditures incurred in one part of the year must be spread over the whole year; (3) budget—because the clinics operate on the budget basis.

In addition to this the books must be so kept that they lend themselves readily to detailed cost accounting and to special cost studies.

The set-up of the budget is as follows:

1. Income—from endowment and gifts; from board and room; from clinic visits.

2. Expense—(a) indirect, which includes general overhead, building maintenance, housekeeping, etc., with the monthly total distributed to hospital, clinics, and to each of the supplementary departments according to good cost accounting practice; (b) hospital direct, which includes all expense items incurred specifically for the hospital, such as nursing care; (c) clinic direct, which includes all direct charges for the clinic.

3. Supplementary departments—each of the sixteen supplementary departments is conducted like a separate business and has its own budget of income and expense and bears a proper share of all the indirect expense plus all the direct expense for the whole project.

Whenever the performance of any part of the whole clinics' project becomes financially unsatisfactory or whenever a study of the operation of similar units elsewhere indicates that the financial performance of any unit might be improved, a detailed cost study of the unit is begun and contained until all proper adjustments in income or expense, or both, have been made.

In August, 1931, the total operating deficit in the out-patient department was studied. The result of this study showed a considerable degree of unevenness in the cost and number of visits in the various departments. All out-patient department costs including all overhead costs were then assessed against the various clinics as accurately as is possible in a first survey. An intensive study was then made of all the cost factors of the one clinic that made the most unfavorable cost showing. It was found that the salary cost was high because of vacations and that some other cost factors were not accurately distributed.

The accounting adjustments were made and certain other adjustments in labor and supply costs were arranged within the next few weeks. The result was that after these changes were completed this particular clinic showed a small surplus. It is, of course, true that this better showing for the one clinic was in part due to a shifting of costs to other clinics by a redistribution of the overhead. The shifting was, however, the shifting of improper charges.

A similar study of the income and expense of each clinic is now carried forward each month.

	Today	To Date This Month	To Date Last Month	This Date Last Year
UNIVERSITY CLINICS				
Free				
Private				
Others				
Total				
Average				
HOME FOR DESTITUTE CRIPPLED CHILDREN				
Free				
Others				
Total				
Average				
LYING-IN HOSPITAL				
Adults				
Babies				
Total				
CLINICS OUT-PATIENT DEPARTMENT				
Number of Visits				
Income per Visit				

CLINICS OUT-PATIENT ADMISSIONS

Today			To Date This Month		
Rate	Number	Amount	Rate	Number	Amount
$10.00			$10.00		
5.00			5.00		
3.00			3.00		
1.50			1.50		
1.00			1.00		
.75			.75		
.50			.50		
.25			.25		
Free			Free		
Prof. Court.			Prof. Court.		
Misc. Free			Misc. Free		
TOTAL			TOTAL		
AVERAGE			AVERAGE		

Dr. Dick's Clinic

Today			To Date This Month			This Date Last Month		
Rate	Number	Amount	Rate	Number	Amount	Rate	Number	Amount

The daily census report.

Emergency operating room in the admission division of Albert Merritt Billings Hospital.

These results are studied so that all proper adjustments may be made. It is not expected that these studies will enable the administration to put each division on a basis that will enable it to produce a surplus or even pay all costs. It is expected, however, that these studies will show where the outpatient deficits are and their size in order that those in charge may make sure the clinics are making the sort of financial progress the administration expects.

Employees' Perquisites Eliminated

One of the hidden costs in most institutions such as the University of Chicago Clinics is the cost of perquisites. In most institutions these perquisites are as follows: (1) for officials—complete maintenance for self, family and guests, which may take the form of handsome living quarters or even a separate house, with guest rooms, food allowances, laundry, house man and maid service, free telephone service, automobile and maintenance; (2) for workers—complete or part maintenance with or without guest privileges; (3) sometimes workers are permitted to produce on the premises and to sell commercially, vegetables, milk, eggs, laboratory animals; (4) other miscellaneous forms of perquisites ranging from free drugs to free furniture repairs.

This system makes accurate cost findings impossible and leads to unduly high costs in many instances. Employees in the clinics are paid a straight salary which is recognized as their total compensation and, in return, they pay for everything they get from the institution. There are just two exceptions to the above procedure. These are: (1) the food handlers, whose compensation is figured exactly like others in comparable salary brackets but with a monthly deduction covering the value of their food and food service—this is merely a journal entry charging the individual account and crediting the cafeteria account; (2) the resident staff. All interns, residents and assistant residents, who live in the house and who get maintenance are given unlimited credit for their own food in the cafeteria, and merely sign their food checks. The cost of this food service is charged to the account known as interns' food and is credited to the cafeteria by journal entry.

Aside from the resident staff, the clinics do not provide housing for employees as part of their compensation. Straight salaries are paid and a few rooms are provided for different groups of workers on a commercial basis. It is possible that it may be found desirable to go into the business of renting rooms to nurses and others on a larger scale. This decision has not yet been reached. The stu-

The private rooms in the Albert Merritt Billings Hospital are furnished in splendid taste.

dent nurses of the Chicago Lying-in Hospital do have their own separate nurses' home.

The University of Chicago Clinics have no central laundry plant and all the laundry, with the exception of that from the Lying-in Hospital, goes out to a commercial plant on a competitive basis. The clinics provide the laundry for the resident staff and for supplementary staff uniforms, but the nurses and other workers provide and pay for their own personal laundry and uniforms. In order to help them obtain laundry service on a right price basis, office space has been given to the representatives of a commercial laundry that serves the clinics. To this office these workers bring their bundles on a cash and carry basis.

Food Service Department Carefully Checked

The University of Chicago Clinics do not have a dietary department as such although many dietitians are employed. It has a food service department that is distinctly a service organization. When it became evident that the elimination of perquisites would necessitate the reorganization of the food service to staff and employees, the advice of a prominent alumnus of the university who is the executive vice president of one of the large hotels in Chicago was sought. Upon his advice a firm of hotel food accountants was called in and they studied the whole problem for several weeks. Upon the advice of these food cost experts the following organization was set up at the University Clinics.

At the head of the food service division and reporting direct to the superintendent is the manager of the food service department. The manager buys all the food and plans all the menus. The next step after planning and ordering is receiving, inspecting and delivering, which is handled by the food stores division under the manager. Raw food is then requisitioned by the various hospital divisions and by the main kitchen. All that is ordered into the main kitchen is issued and charged out in the form of cooked food. As a part of the service rendered by the food cost accountants, standard recipes have been set up and the cost of each ingredient is determined, together with the number of standard portions each recipe produces and the cost of each standard portion.

The flow of food and food charges then is from the vendor to the storeroom, from the storeroom to the single main kitchen and the special diet kitchen, from the kitchen to the various hospital divisions and to the two cafeterias. Each step is costed and the inventory at the beginning of the month plus the purchases must, at the end of the month, approximate the value of the food charged

to the various units plus the inventory at the end of the month.

There has been some discussion of the relative advantages of a steward and a chef or an administrative dietitian as head of the food service department. We prefer to place the responsibility upon a dietitian because we believe:

1. That maximum economy and efficiency may be secured only where the person who controls the menus controls their execution, both as to buying and preparation.

2. That dietitians are not as easily "reached" as are stewards.

3. That the type of mind which is typical of the best administrative dietitians is peculiarly adapted to the rather minute planning and management of food buying, food preparation and all other branches of food service.

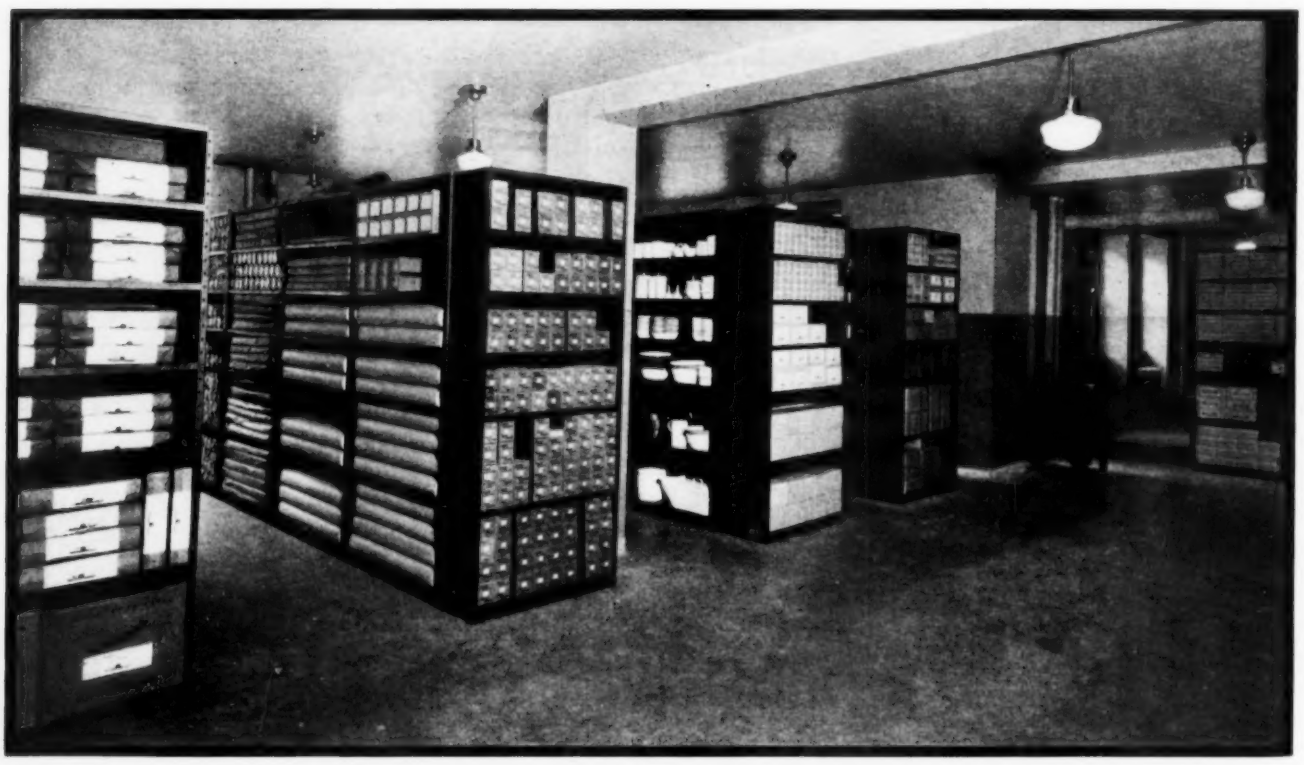
4. That we can obtain the services of a much higher type of person as a dietitian than as a steward.

A detailed description of the operation of the food service department will appear in a future issue of The MODERN HOSPITAL.

In most hospitals there are from two to ten supplementary departments, the accounting for which is buried in the cost per patient day. This means that both income and expense for board and room and nursing care are understated. The administration of the clinics believes that for this organization, at least, it is better to separate all these supplementary departments and to set up each as a separate producing unit with its own budget of income and expense and its own surplus or deficit estimate.

There are two reasons for this: (1) It gives the administration an opportunity to know just what surplus or deficit is being produced by each little unit. If a surplus is produced the performance of this unit is compared with outside commercial units performing the same or similar service in order to determine whether the unit is being efficiently administered. If the operation of that unit produces a deficit, an attempt is made to reduce that deficit and to decide whether it is worth while to have the service of that unit and to absorb the deficit or to make other plans. (2) By stripping off all the extraneous income and expense items from the main project the administration is enabled to make more accurate studies and to plan more carefully for the operation of the main project—the providing of board and room, nursing and professional care for the sick.

The indirect expense is prorated to the hospital, to the out-patient department and to each of the supplementary departments on an accurate cost accounting basis. This then throws both the income and expense into two main headings, hospital and out-patient department, and sixteen supplementary department headings. This method enables those in charge to know where each unit stands at the end of each month. By the use of



The neat arrangement of the clean linen room at Billings Hospital eliminates confusion in locating supplies.

the night bookkeeper's report it is possible for the administration of the clinics to know the condition of each department at the end of each day.

The effect of this accounting plan on the various supplementary departments may be illustrated by the pharmacy. The other departments operate in much the same manner.

The pharmacy is managed by a registered pharmacist who reports to the superintendent. She is assisted by four other registered pharmacists and a porter. During busy times and for vacation relief another part-time registered pharmacist is employed. In all the details of management the pharmacist is given a great deal of freedom. She may buy what she likes and where she pleases. Her orders are handled through the office of the purchasing agent of the university and all her requests to purchase pass over the desk of the superintendent, but his check is largely routine. The manager of the pharmacy is held for two kinds of results: (1) She is expected to please and satisfy her clientele of patients, clinicians and divisional heads. (2) She is expected to produce a certain net surplus each month. Her stock is inventoried at least twice each year.

The pharmacy is charged with all purchases, with salaries, light, heat, housekeeping, maintenance of the building, care of equipment and general overhead. Up to date it has not been charged with depreciation but this item of expense will be added soon. The pharmacy is also credited with all cash sales, and with all collections on account for the pharmacy. Credit is also given for all sales to the various divisions of the hospital, the outpatient department, and to other supplementary departments, on the basis of cost plus the labor of preparation, if any, plus a 5 per cent handling charge.

Admitting Is Difficult Task

The operating suite is also set up as a separate producing unit under the management of the supervisor who is responsible to the superintendent of the clinics through the superintendent of nurses. Here again the unit is managed like a small business being charged with the following items: nursing and under staff salaries, salaries of anesthetists, general supplies and expense, anesthesia, laundry, housekeeping, light, heat, care of equipment, maintenance of building, repairs and overhead.

The admitting office of any large clinic is one of the most interesting and certainly presents greater difficulties than any office in the whole complicated set-up. A single staff is used to handle the admission of patients to both the clinic and the hospital. The task assigned to this office is to reconcile the demands of three different groups and to see that in so doing the interest of the patient is protected. The medical staff demands that the admitting office admit the patients in whom they are interested regardless of the patients' ability to pay. The superintendent demands that the admitting office maintain a certain average income per visit and per hospital day in order that he may balance his budget, and the social service department is concerned with getting needy cases cared for regardless of their medical interest or their ability to pay. These conflicting demands have made the post of admitting officer difficult and arduous.

Beginning with February, 1932, the medical staff agreed to certain limits upon the number of free and part-pay hospital patients on each service and this has done much to simplify the work.

A Medical Sorting Device

Patients who apply at the admitting office of the clinics first fill out a brief registration form and then are seen in the consultation clinic. This clinic is merely a medical sorting device. Each patient is briefly interviewed by a member of the house staff who classifies him in code according to his medical interest. After this brief interview he is seen by an admitting officer who either accepts or rejects him on the basis of the medical sorting plus his ability to pay. If he is accepted he is given a financial classification and all the charges are explained to him.

At any time during the patient's treatment his financial rating may be reviewed and if circumstances warrant, his rate may be adjusted either up or down. This review may be initiated either by the patient or by the admitting office. While the long hours the admitting office is open require a certain amount of rotation of the staff, insofar as possible the same admitting officer takes care of the same patient all the way through.

If the patient should be hospitalized the same admitting officer who set his clinic charges would, if possible, set his hospital charges.

The foregoing routine refers to regular clinic patients. Private patients paying private rates are merely registered and are seen as promptly as possible. A private patient who is known to the clinic or who is referred there by a friend of the institution is met at the front door by a uniformed doorman who has been given the patient's room number and who takes him directly to his room. After the nurse in charge has seen the patient put to bed she telephones for an admitting officer who comes to the patient's room and completes his registration. Insofar as possible the service is taken to the patient rather than have the patient go to the service.

What Others Are Doing

A Birthday Club Fund

In order to continue its orthopedic department for crippled children the Tacoma General Hospital, Tacoma, Wash., has organized the Edward A. Rich Memorial Birthday Club for Crippled Children. The club is named in honor of the late Doctor Rich who was for many years chief surgeon in the hospital's orthopedic department.

Membership in the club is $1 for active membership, $5 and up for sustaining membership and $200 for life membership. The hospital estimates that $600 to $750 a month will be paid into the club which will nicely carry the deficit of the orthopedic work.

A postcard with the following message is sent the prospective member on his birthday:

"On this day ..... we extend to you Birthday Greetings, and express the hope that your year will be filled with health and happiness.

"Let us not forget the children who are looking to us for aid, that they too may have years of health. With this thought in mind, we give you the opportunity of again sharing your good fortune with the unfortunate children of our city."

"I want people to think in terms of giving on their birthday, rather than receiving," writes C. J. Cummings, superintendent of the hospital.

An Economical Painting Process for Hospital Furniture

Painting hospital furniture has always been an expensive proposition. Until recently the John Sealy Hospital, Galveston, Texas, kept one of its painters busy at this task. When a painter was dropped from the pay roll in order to reduce expense, the same work had to be done with less help.

A spray machine seemed to be the solution. A small outfit was purchased and mounted on a truck for easy transportation. It was found that furniture, radiators and small objects could be painted in about one-third of the time consumed by hand painting.

Removal of old paint from furniture was the next problem, which is necessary in order to secure a good job.

In order to reduce the time required for this process, a reinforced concrete tank 7 feet long, 4 feet wide and 2½ feet deep was built in the paint shop. It was equipped with a drain, water supply and a steam coil. This tank is filled with a solution composed of 24 pounds of lye to 175 gallons of water.

Furniture is submerged in this solution, steam is turned into the coil and the solution is boiled for twenty to thirty minutes. The solution lasts for a long time if water is added to compensate for evaporation. If too much foreign matter accumulates in the tank

the lye solution is drained off, passed through a screen and put back into the cleaned tank.

After this treatment in the tank paint can be removed from the furniture with a stiff brush. The furniture is then sprayed with water to remove all trace of the lye solution. The smooth metal surface is then ready to be painted with the spray machine.

Profitable Control of Splints and Crutches

All splints and crutches at Regina General Hospital, Regina, Sask., were formerly kept in a room convenient to the cast room and accessible to everyone. As a result the hospital was constantly buying splints and yet the one required at the moment was never available.

Under a newly adopted plan, according to S. T. Martin, superintendent, all splints were removed to a convenient central supply room where they were placed in a locked cupboard. On the door of this cupboard is a chart showing an illustration of each splint in stock, the number of each kind on hand, the cost price and a rental price based on an estimated number of times each splint can be used.

Since there is no surgical supply house in Regina, the hospital's supply of splints is used not only for hospital patients but also by the attending staff for their own out-patients.

For the hospital's records a triplicate form is made out and a rental charge is made, whether the patient is a hospital bed patient or an out-patient. No splints are charged to out-patients. These must be paid for in full or else charged to the patient's doctor. A credit is issued in either case, less the rental when the splint is returned.

One copy of the form is sent to the business office as a charge. Another is kept until the splint is returned, when it is filled out and sent to the business office to complete the transaction. The third copy remains in the supply room as a record of the transaction.

Splint costs have been reduced from several hundred dollars a year to a very small sum for replacement of worn splints. The hospital reports a small profit on its investment of splints and, still more important, a definite supply of splints is always on hand.

The supply room has in stock an assortment of sizes of crutches which are painted black up to the hand grips. These are conspicuous and cannot be taken out by patients without being checked. When a ward patient requires crutches while he is in the hospital, the ward requisitions a pair from the supply room. These are held as a charge against the ward and credited when returned. If on discharge the patient still requires crutches, he buys them through the stores department. If they are returned in good condition a refund is made, less a rental charge of 50 cents a month.

The Student Dietitian Learns to Buy

In order to instruct student dietitians in the economic as well as the dietetic aspects of their work, Johns Hopkins Hospital, Baltimore, arranges that they shall assist in the purchasing of food and shall help to keep account of the per meal food costs. Part of the food at Hopkins is purchased through the hospital purchasing department. Fresh vegetables, however, are purchased by the dietitian accompanied by a student. After several trips with the dietitian, the student is sent to make purchases alone. A monthly record of food costs is kept, and also of costs per meal.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

Good Ward Teaching—the Essential Factor in Nursing Education

By SISTER M. DOMITILLA
St. Mary's Hospital, Rochester, Minn.

Given a well qualified and capable director, the most important measure for a nursing school to consider is the improvement of the teaching methods practiced on its wards. Without good ward teaching methods it is absolutely impossible for training schools to turn out graduates sufficiently well qualified to represent the nursing profession

THE apprenticeship system in nursing education has been condemned so roundly in the last few years that its continued existence is problematical. Before jettisoning this ancient practice entirely, would it not be well to examine it critically so that we may be sure its reputed defects are inherent? Perhaps it is not the system that is at fault but our application of it.

In a recent book on apprenticeship, Stewart Scrimshaw, Marquette University, Milwaukee, states that "all modern education is acquiring more and more of the apprenticeship principles. Increasingly do we see the tendency to combine work and education, theory and practice." Educators who are familiar with this type of education agree that the experience that students get in their cooperative work results in the acquisition of skill in their chosen profession and the development of sound and desirable attitudes toward the problems that confront them. They learn how to work with others. This knowledge of how to get on with people cannot be taught. It must be learned by each individual through actual contact with the class of person with whom he must deal.

Cooperative Education Builds Character

"Most people who know cooperative education intimately say that one of its outstanding merits lies in the field of character building," writes another author. "They will point out that the experience which the student gets at work matures him and gives him an increased sense of responsibility; that his courage, resourcefulness and stamina are tested; that self-confidence and initiative are developed."

Those are the character traits we want in a nurse and I believe we have been fairly successful in developing them primarily because we have clung to some shreds of an old, tried, practical method of education. If nursing education has failed, it is not because of the apprenticeship system, but because of improper application of the principles of apprenticeship.

We are fond of saying that nursing is an art. But what is an art? It is skill in applying knowledge. Knowledge is fundamental, but the individual who possesses knowledge which is not skillfully applied is not an artist. Nursing is a fine art as truly as the production of beautiful music or of exquisite paintings is a fine art. It is the art of all arts because it deals not with marble or other inanimate things but with the human being, the masterpiece of creation.

The methods used for educating and training nurses, therefore, ought not to differ materially from the methods used in the schools of fine arts. These methods are: first, selection of students with sufficient capacity and special talent; second, sound training in technique; third, provision of models to be emulated; fourth, assistance in building up a background of experience, and, finally, creation of

an atmosphere conducive to desirable achievement. It is unreasonable to believe that any intrinsic distinctions thrust the art of nursing beyond the pale of the same conditions of environment.

In order to train young women in the art of nursing it is necessary that we have women of sterling character, free from unfortunate personality traits, well educated, trained to think and able to serve. In selecting our applicants we ought to make use of the new techniques worked out by modern psychologists. It is difficult to say just how valuable they will prove but the sooner we give them a trial the sooner we can tell.

This Phase of Training Must Be Retained

After the student has been carefully selected, she needs adequate training in technique; close contact with models in the profession; sufficient experience, and an atmosphere conducive to reasonable attainment. These four educational factors are all intimately connected with hospital wards. It is the hospital ward which is the real school of nursing.

As previously stated, nursing education involves knowledge and skill in its application. Much of the knowledge that a nurse needs can be acquired in a college or university as well as in the classrooms of the hospital. But skill can be acquired only by caring for the sick under the direction and supervision of graduate nurses who are models in the profession. The hospital is the only place where it is practicable at the present time for students to acquire finished technique and a background of desirable experience. It is this phase of apprenticeship training which we must retain.

The person in charge of the hospital ward or floor is the key person in the school of nursing. Unless she is in sympathy with the training program, it is impossible for such a program to succeed. She is the person who controls the education of the student eleven hours out of every twelve. She is the person responsible for developing in the student an appreciation of all that is fine in nursing.

The first survey of schools of nursing made by the Committee on the Grading of Nursing Schools reveals that, after the preliminary period is over, eleven or more out of every twelve learning hours are spent in nursing practice. So even in schools which have an excellent staff of instructors, the education and training of the student are little influenced by them. Dr. May Ayres Burgess after analyzing the situation says, "Most of the real instruction which the student nurse receives is given by the supervisors and head nurses under whom she works and by the graduate floor duty nurses with whom she comes in contact. Night duty, which, according to the testimony of many nurses, gave them more valuable training than any other part of their experience, is under the direction of the night supervisors. If they are fine women and good teachers, the student learns much. If they are not, she may also learn, but in a manner which is to be regretted."

Should the head nurse be responsible for the ward teaching? Perhaps. In some institutions or in certain departments of a given institution the head nurse might be the best person for the work. In other departments or institutions the supervisor would be the person best qualified. In still other places special teaching supervisors may be the only solution. Institutions vary like individuals and a plan successful for one may not be for another. Schools should be free to experiment in this matter. For purposes of discussion we shall speak of the head nurse as the individual responsible for ward teaching.

What qualifications do we want her to have? Besides being a model nurse she should possess the attributes of all good teachers—knowledge, pedagogical skill, vision, sympathy, enthusiasm. Above all she must be actuated by the highest ethical and professional ideals. The forces that form and build character must underlie all nursing education. It is extraordinarily significant that, in "Nurses, Patients, and Pocketbooks," published by the grading committee, nearly all the complaints made against nurses involve low ethical standards or ideals of service. This emphasizes the necessity of selecting students carefully and of employing for the teaching and administrative staff women of high rank in their profession who have the personality, the intellectual ability and the character that qualify them for leadership.

Teaching by Example

The person who does the ward teaching must be first and foremost an excellent nurse. Is this qualification more important than a degree? Yes, it is much more important. Is it more important than skill in formal teaching? Yes, by far. There is much unconscious teaching going on in the hospital all the time. If the head nurse is an ideal nurse, she will teach more by her example than most of us realize. Some of our older women who have not had the opportunity for special training are excellent ward teachers because of their admirable skill in nursing, their long experience, their devotion to the welfare of the patients, and their interest in the students.

The head nurse who does ward teaching must have a love for teaching and an ability to teach. By ability to teach, I do not mean simply skill in conducting classes, but capacity for inspiring stu-

dents with a genuine love for nursing. We need head nurses who are intellectually alert and alive and who rejoice in teaching the students under their charge. A head nurse with a blasé air of superiority or with the attitude and technique of a dictator should not be entrusted with the molding of young lives.

Courses are now offered to nurses interested in ward teaching. Head nurses and supervisors should avail themselves of the opportunity to take such courses. Young women who are interested in ward teaching but who have had no experience should first seek advice relative to their fitness for such work. If they have the personal qualifications, they certainly should avail themselves of the courses offered. The old method of training supervisors and head nurses by merely exposing them to the job is no longer adequate. It is too wasteful of time, effort and strength.

A Unified Program Is Needed

In order to carry out a program of ward teaching successfully, a certain amount of organization or machinery is necessary. There must be coordination between classroom instruction and ward practice and between the various hospital services. This can be accomplished only by deliberate planning and vigorous activity. It is disastrous to good teaching, for example, if the instructor in principles of nursing demonstrates one method of administering a drug by hypodermic injection, while on the wards there are as many different methods being used as there are head nurses. It is also not uncommon to find one head nurse very punctilious in making reports of the work of students while another, if she makes a report at all, classifies all students as "excellent" or "impossible."

To promote and unify a good program of ward teaching the active cooperation of the whole faculty is necessary. There must be regular staff meetings to determine what the teaching program shall be and how it shall be carried out. At the first few meetings of the faculty and at regular periods thereafter the time should be devoted to an analysis of teaching facilities. Every head nurse, operating room supervisor and dietitian should make out a detailed list of all the educational opportunities in her department. This will make her aware of the teaching facilities at her command and enable her to determine what procedures are peculiar to certain wards. If the head nurse finds that there are some procedures peculiar to her ward, certainly she must assume the responsibility of demonstrating those procedures to the students when they come to her and of making sure that they become proficient in their execution. Even though the student has had the procedure demonstrated in the classrooms, she is not likely to have the opportunity to practice it on the wards immediately. Student nurses forget, as we all do; hence the need for repeating the demonstration.

Many staff conferences should be devoted to research and training. If, for example, there is some question or disagreement about the thermometer technique, that is a problem admirably suited for research. A committee should be appointed to make a thorough study of the disinfectant solutions used and the procedure desirable. It is well to inveigle a physician into assisting with such a study. After the committee has completed its study, a report should be made to the entire faculty and some procedure recommended. If the procedure is accepted, it should again be carefully presented so that every head nurse may be thoroughly familiar with it. It will then be necessary for her to demonstrate the new procedure to the students under her charge and to give it special attention.

Changes in nursing procedures, changes in standing orders, complaints of patients and physicians, and the abuses and irregularities that are bound to occur in every institution, all should be taken up at the staff conferences for discussion. There is no other way of managing an institution efficiently. There is no other way of creating an atmosphere conducive to successful attainment.

The success of the staff conferences will depend to a great extent on the attitude of the director. Friendliness and openmindedness are two necessary qualifications. Through these she will secure spontaneity and will dispel any feeling of inferiority or of resentment on the part of the head nurses. The successful director will discover those things in which her workers excel, she will direct their attention to the good points in their work and will make progress in her program through the encouragement that comes from viewing such success.

Evaluating a Student's Success

The director will also need to have much patience and persistence. She will need to remember that a good head nurse will be much more interested in the nursing care of her patients and in a smooth running department than in problems of education. It may require infinite patience and many months, even years, of effort to give her an awareness of teaching problems and opportunities, and a desire to do anything about them. But in the end she will be a more valuable member of the faculty than the expert teaching supervisor who is not so much interested in the practical problems of nursing and administration.

Another important detail of organization is the

efficiency report of the head nurse. The problem of the elimination of students lacking in personal or professional qualifications is closely tied up with that of selection. Even though we use every possible means for selecting the most desirable applicants for our schools of nursing, we find it necessary sometimes to dismiss students from our institutions because they are unpromising or inefficient.

The factors that should be taken into consideration in evaluating a student's success are scholastic achievement, physical fitness, personality traits, character traits and nursing ability. The first factor, scholastic achievement, may be measured by classroom performance but all the others can be best determined by observing the students on duty. It is imperative, therefore, that the head nurse make detailed and comprehensive reports relative to each student under her charge.

In many institutions it is customary for the head nurse to fill out an efficiency report for the student when she leaves the department. It has been found much more satisfactory, however, to have the head nurse make reports the first of every month for all the students who have been in her department for two weeks or more. There are at least two advantages in this plan. First, if the report is a matter of routine, it is not likely to be neglected or forgotten. Second, the student will probably receive at least two reports in succession from one department. If the first is not satisfactory she is made aware of her failings and is likely to put forth greater effort in order to have the second report satisfactory.

Many types of ward reports are in use at the present time. Some are unsatisfactory because the traits used as criteria are too vague or too general. Others do not have a sufficient number of criteria. Many are unsatisfactory because they are difficult to score.

The organization for ward teaching can be made elaborate but we should remember that the simpler our machinery, the less likely it is to get out of order. The two phases of organization just discussed, conferences and reports, are absolutely essential to successful ward teaching.

Through the work of the grading committee it has been clearly demonstrated that most schools are eager to improve, they are anxious to learn what must be done to strengthen the nursing course. I believe that, given a well qualified director, the most important measure for a school to consider is the improvement of its ward teaching. Without good ward teaching we are not able to turn out young women who are well qualified to enter the nursing profession. We are not going to succeed in making nursing the art of all arts.[1]

[1]Read at a meeting of the Kentucky League of Nursing Education.

A Bit of Hospital History

Twenty years ago this month:

The first issue of The MODERN HOSPITAL was published.

England was measuring the results of the first year's operation of the British National Insurance Act.

Sanitary laundry chutes were just being introduced into hospitals.

The American Hospital Association was planning to hold its annual convention in Boston with Dr. Frederic A. Washburn as president.

California passed a law limiting pupil nurses to an eight-hour day.

Doctor Thompson by use of pedometers found that nurses walk seven and one-half miles a day.

Michael M. Davis was director of the Boston Dispensary.

The late Dr. Theodore Sachs urged that general hospitals admit tuberculous patients.

Dr. S. S. Goldwater, then superintendent of Mount Sinai Hospital, New York City, declared that "the hospital unit today is a stumbling-block in the road of progress."

The trend toward the city, the increased cost of living and the necessity for woman to work, according to the late Dr. Henry M. Hurd who had recently retired as director of Johns Hopkins Hospital, have done away in great measure with the home care of the sick.

Sir William Osler declared that most hospitals were inadequately prepared to prosecute bacteriological and pathological research.

The late Dr. Herbert B. Howard, superintendent of the newly opened Peter Bent Brigham Hospital, Boston, stated that there were twice as many hospitals as there had been three years earlier.

The ownership of x-ray plates was a live topic.

The late Dr. L. B. Baldwin was elected chairman of the hospital section of the A.M.A.

Chicago was boasting of a new Cook County Hospital.

Intelligence Tests Would Cut Waste in Nursing Schools

Approximately $5,000,000 is spent fruitlessly each year by schools of nursing in the United States in attempting to train students who do not complete the prescribed course, it is estimated by Dr. Elsie O. Bregman, Columbia University.

Waste from this source could be considerably reduced by the use of intelligence tests as aids in the selection of candidates, Doctor Bregman believes. She has studied the intelligence ratings of more than 10,000 student nurses. She finds that schools requiring high school graduation as a minimum entrance requirement get a higher type of student. Doctor Bregman's data show that the distribution of mental ability among student nurses resembles that found among students at normal schools, and is slightly superior to that of high school seniors.

Sheboygan Hospital Is Well Planned and Ideally Situated

By

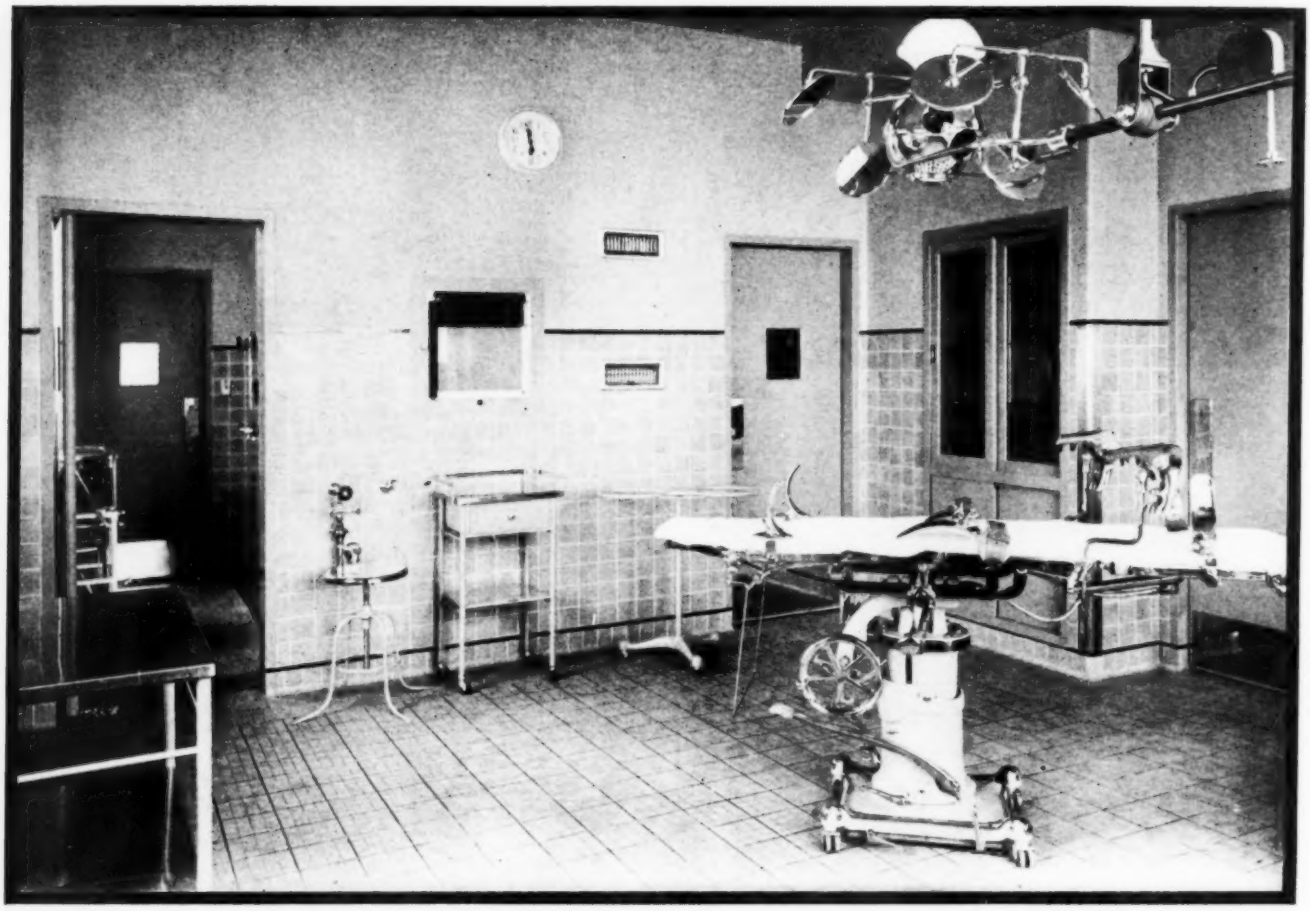
RICHARD E. SCHMIDT

Schmidt, Garden and Erikson, Architects, Chicago

SHEBOYGAN Memorial Hospital, Sheboygan, Wis., is in a quiet, new, residential district, a recent development which has not reached its full occupancy and will consequently remain desirable for many years. It is unlikely, therefore, that the hospital will ever find itself in a run down, noisy portion of the city, surrounded by business and industries or by dilapidated family residences. Neither will it suffer from smoke, dust or industrial process odors.

The hospital was opened in January, 1933. Among its advantages was the conviction on the part of its officers, directors and building committee members that laymen should not select a site or decide certain other physical matters except upon the advice of specialists who have seen, surveyed and checked the operation of many hospitals. The Sheboygan Hospital Association, therefore, employed the architects and the hospital adviser before the site was purchased. These men inspected several available sites and tested their adaptability to the requirements of a hospita! by preparing studies and surveying the neighborhood.

The site provides all of the requisites usually set up by hospital experts. It is desirable from the standpoint of transportation, soil, elevation, drainage, water supply, power, communication and accessibility. Its size will permit the expansion of the hospital in accordance with twentieth century developments. There is ample parking space for patients' visitors and separate parking space, to the capacity of seventy-five automobiles, for the use of the medical staff, adjacent to a special entrance, where it will detract least from the hospital's appearance. Furthermore, the site is adequate for doubling the capacity of the hospital, its parking spaces and all services. Before completing the



building plans, careful studies were made to determine that additions when required might be made in an orderly fashion.

One other unusual feature was that arrangements were made at the outset for landscaping so that lawns were in perfect condition and shrubs were in leaf and in bloom in the spring following the opening of the hospital. The earth from building excavations was not removed from the site but was put wholly into terraces and other desirable contours, covered with black earth, seeded and planted with shrubs and trees. An underground system of piping with 175 concealed sprinkler heads, controlled by a battery of valves at a position convenient for manipulation by an employee, was installed and operated during the construction of the building.

The landscaping of the ground around the kitchen wing in the form of a sunken garden supplies the kitchen with as much light and air as it would have if it were in a higher story, and makes it possible to separate from the nursing and treatment floors all traffic of carts, trays and food deliveries. This arrangement demonstrates that it is not necessary to use for the kitchen a valuable upper story which is needed for other hospital services.

In the planning there is more than the usual

One of the major operating rooms is shown above. Automatic humidity control and a grounded brass grid in the floor eliminate the dangers of static spark. Below is an antiscalding shower stall in the obstetrical department.

segregation of services—administration and visitors, laboratories, treatment rooms, operating department and others. The culinary department is a self-contained unit set apart from the activities of other departments.

Food is distributed by means of carts. The carts are routed from the kitchen to the serving rooms and, returning, to the dishwashing room and then to the normal station. Each food cart has a special self-contained hot water heating system, consisting of a small tank and water coils for keeping the food warm for the necessary distribution period. Before the food carts are loaded this water system is heated by electric current which is carried to an electric heating element which is part of the equipment of each food cart.

The nurses' dining room is arranged for waitress service or self-service.

Interns' Quarters on First Floor

In addition to the main and general entrances there is a side entrance for patients arriving by ambulance, for delivery of goods and for the use of the medical staff.

The first floor contains administration, physiotherapy, emergency and teaching sections, as well as laboratories and quarters for four interns. The latter are conveniently placed for the interns to answer calls from the office and from the ambulance entrance, as well as telephone inquiries from members of the attending staff. The public and administration quarters are arranged to function smoothly. The record room, the conference room and classrooms are separated by soundproofed doors. Together these rooms provide a meeting place for 100 persons. Patients' rooms are on the second, third and fourth floors.

The Operating Department

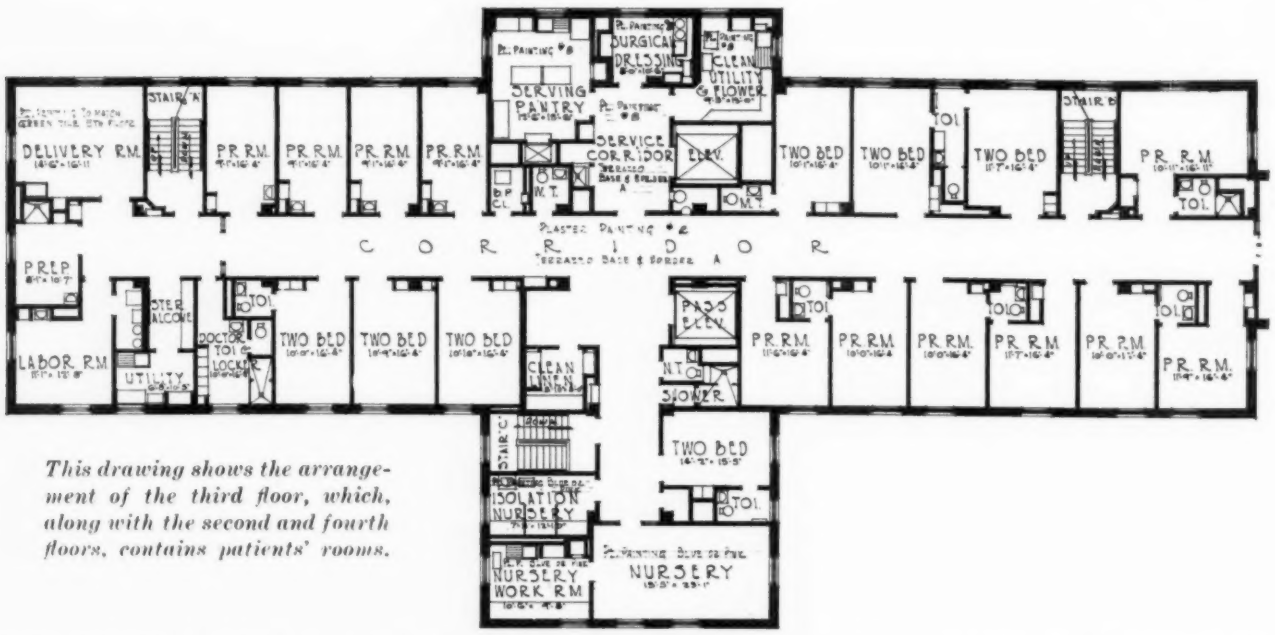
Wards and private rooms have been provided for ninety adults and twenty-four bassinets. The adult capacity can be increased to 100 by placing a second bed in each of ten large private rooms that now have only one bed but have floor area, air content and auxiliary items adequate for two patients.

The location and arrangement of the operating department are noteworthy. Ventilation and lighting are accomplished by windows on four sides. In addition there is a separate exhaust fan that will remove 2,000 cubic feet of air per minute. By remote control this fan may be started or stopped by the operating room nurse. This arrangement of controlling the special exhaust fan has many advantages.

Operating room radiators are of the copper fin type, built into the outside wall under the windows. Each radiator is contained in metal housing and provided with top and bottom grilles and damper control on the top outlets.

The major and minor operating rooms have humidifiers, which for safety consist of a spray of

The first floor contains administration, physiotherapy, emergency and teaching sections, as well as laboratories and quarters for four interns. The record room, the conference room and classrooms are separated by soundproofed doors.



This drawing shows the arrangement of the third floor, which, along with the second and fourth floors, contains patients' rooms.

warm water discharged in a metal housing concealed in the wall. The pump and the temperature control for this water are in the penthouse and each humidifier is controlled by an electric pilot valve in the pipe space. These valves are opened and closed by a special sparkproof humidistat in the operating room. The humidifiers maintain from 50 to 60 per cent relative humidity in the room and are so constructed that they guard against a combination of heat and moisture which would form an incubator effect that would be undesirable in the operating department of the institution.

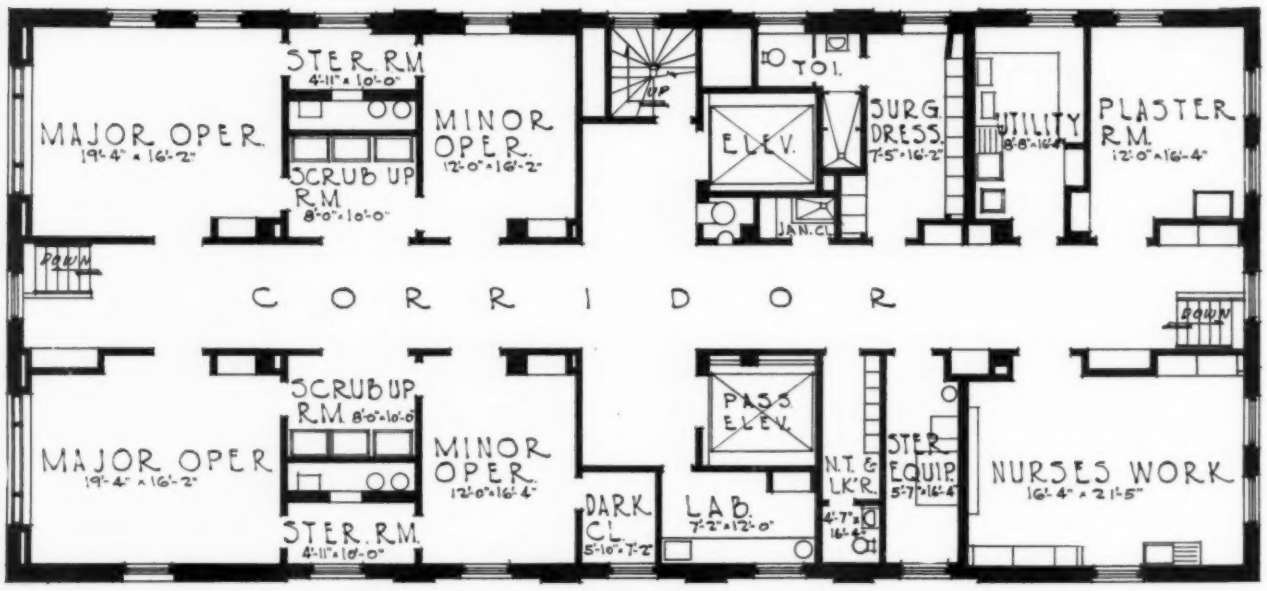
Brass grids, installed in the joints of the tile which practically covers the operating room floors, are electrically grounded. Electric light switches of the mercury type minimize the danger of gas explosions.

Suction and air piping outlets are provided in each room. The machinery for these is in the penthouse for safety, and remote control is provided so that the operating room nurse can start and stop it at her convenience.

The x-ray film storage vault is a sprinklered, fireproofed vault in the top of the tower, ventilated and situated as recommended by experts and authorities.

Red face brick and Indiana limestone are used for all of the exterior of the hospital boiler house and smoke stack.

The construction of the first floor and all columns and girders are of reenforced concrete. Other



The operating department is on the fifth floor of the building. This entire floor is wainscoted with matt glazed tile. There are two major and two minor operating rooms, with windows on four sides.

floors and roofs are of steel beams with a slab of concrete, with electrically welded steel fabric and ceilings of metal lath and plaster. Interior partitions in the basement, around stairs and elevator shafts, are of clay building tile and other partitions are of gypsum block.

The stairways are reenforced concrete construction covered with terrazzo and fitted with ornamental iron railings. The use of tile for floors, wainscoting, wall covering and floors on porches and roofs is more liberal than usual. Door frames throughout the hospital are of steel.

The children's playroom, corridor runners and hall bathroom and toilets are wainscoted with matt glazed tile.

The low wainscoting in the reception rooms, the wood trim and wood fixtures of the offices are of American walnut and this wood is used for the doors throughout.

In the administration portion of the building enameled wood Venetian blinds have been hung instead of cloth shades.

The ceilings of the operating, delivery, labor, service and many other rooms are covered with sound absorbent material, and this material is applied throughout the hospital as liberally as is

The floors and base of the kitchen are of red quarry tile, the walls of mottled light green terra cotta and the ceiling of sound absorbent material. The basement kitchen is light and airy, due to a surrounding sunken garden.

elevator cabs are floored with ¼-inch marbleized rubber tile. All other floors in the hospital, except those of storerooms and machine rooms, are of terrazzo, the color of the field differing from but harmonizing with the flush sanitary bases. The terrazzo floor in the reception room is laid in pattern. Floors of the kitchen, dishwashing and other rooms of the culinary department in the basement are of red quarry tile. The walls are cream and sea green mottled textured terra cotta blocks from floor to ceiling, standing on red terra cotta bases, with highly glazed black tile bands on the base and immediately under the ceiling.

The operating department and delivery department are wainscoted with matt green tile. All other tile is cream color. The entire fifth floor, the consistent with reasonable expense. Floor and roof construction were also selected with a view to controlling noise. All corridors have rubber flooring and ceilings are covered with sound absorbent material. The doors of rooms where noises usually originate are soundproofed. All motors and fans stand on sound absorbent pads and the elevator machine stands on several pads of different materials and several air spaces.

Commodious metal lockers have been placed in every ward and private room for the maximum number of patients. Lockers are divided into separate compartments for bedside utensils, clothing and patients' linen.

The boiler house and refrigerating plant are connected with the hospital by a tunnel. The

The nursery utility room is equipped with a porcelain combination sink and laundry tray with back, on two porcelain legs. The drainboard is of wood.

foundation of the boiler house was planned to provide for the addition of a laundry, the management having decided to patronize commercial laundries for the present.

The ash hoist and coal bins are at the greatest possible distance from the hospital so that the boiler house serves as a barrier to the noise incidental to the movement of coal and ashes.

The power plant is in a building detached from the hospital and contains two 125-H. P. return tubular boilers, with a working pressure of 150 pounds. It is operated for the present at 125 pounds pressure. The garbage destructor is in the power house so that its care can be under the direction of the engineer.

There is an eight-ton refrigerating machine, steam driven, and an ice freezing tank with a capacity of 1,200 pounds of ice a day. Two brine circulating pumps circulate the brine through the hospital boxes. Intermediate pressure steam is used in the sterilizers and kitchen equipment.

The heating system is a low pressure vacuum system and hot water is heated in the U tube type storage hot water heater in the power house. All condensation returns from the intermediate pressure lines and from the heating system are carried back to the feed water heater and thence are returned to the boilers by the boiler feed pumps.

An automatic gasoline fueled generator is provided for the operating rooms and emergency lights for the public service quarters.

All supply and return lines in connection with the intermediate steam services and the concealed return lines on the heating system are copper. The remainder of the piping is wrought iron. Pipe space with walks and flush metal access doors makes pipes and valves accessible.

A modern two-story residence which stood on the premises when the site was purchased has been converted into a residence for the superintendent and supervisors.

Schmidt, Garden and Erikson, Chicago, were the architects. The associate architect was E. A. Stubenrauch, Sheboygan, and Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago, served in the capacity of adviser on the project.

What Is Minor Surgery?

One of the difficulties encountered by most hospital superintendents is the definition of terms as it affects the allotment of privileges to members of the institution's staff. This trouble also arises when the fixing of charges for hospital service is to be decided. Certain members of the visiting staff are fully capable of performing all types of surgery. No difficulty arises in allotting privileges to this class.

Frequently members of the junior staff desire to perform what they term minor surgical operations in the dispensary and on paying out-patients. There is no question but that the hospital should in some way render to staff members a service which includes the providing of operating room facilities, anesthesia and dressings for the performance of so-called minor operations on out-patients.

The difficulty arises when the institution endeavors to decide the limitations of minor surgery. Often a young and aggressive physician needs to be decidedly curbed as to the type of surgical work which he would perform were he allowed to do so. The incision of a furuncle, the performance of a circumcision, the removal of a wen, the suturing of a laceration and perhaps the setting of a fracture of a wrist or a phalanx represents the type of surgical work often considered as minor. And yet an operation which may be truly minor to a trained surgeon may be in reality of major proportions to a young and untrained physician. Deaths from anesthesia, no matter how trivial the operation was to have been, are tragic accidents that occur too often.

The safest method to pursue is for every operation to be considered important and dangerous and for the institution to be exceedingly chary in granting surgical privileges to any but seasoned surgeons. If the younger generation of physicians is to gain experience through working in and about the hospital, sufficient supervision must be given to these men in order to guard against untoward accidents. The present day changed attitude in regard to the seriousness of a tonsillectomy is surely justified.

It is impossible to set down a complete list of minor surgical operations and to grant privileges on the strength of such an enumeration is unwise. The qualifications of individuals desiring to perform any type of operation must be considered before any condition may be classified as either major or minor.

Strict Aseptic Technique Is Required in the Contagious Unit*

By F. G. CARTER, M.D.
Superintendent, Ancker Hospital, St. Paul, Minn.

IN THE last few years much has been said about the hospitalization of contagious diseases in the general hospital. Today this practice is being carried out in a number of institutions with satisfactory results. In proper hands it is theoretically and practically sound and presents no great difficulties if the details of operation are carefully thought out and planned in advance.

However, the hospital executive who undertakes such a project must know beyond any doubt what he is about, which means that he or someone in his organization must thoroughly understand all the details involved in the application of the principles of asepsis and must be willing to shoulder the responsibilities attendant upon strict enforcement of rules of technique. We can't just go through the motions of practicing medical asepsis. It must be more than a gesture. It must be approached with every ounce of thought and concentration that can be summoned to the task. The director or supervisor must strive continuously for a hundred per cent observation of the principles involved on the part of all concerned. Under any other conditions it is better for the general hospital to exclude contagious diseases.

Indifference Must Be Overcome

The hospital that teaches its personnel to practice an unfaltering aseptic technique teaches a mode of living that will yield big dividends in health throughout the lives of these individuals. They learn that this technique has a practical application to ordinary living conditions. This training is in large part the answer to the question so often asked "Why do not doctors and nurses more frequently acquire the diseases of the patients whom they treat?" No part of the educational program of doctors, nurses and other hospital attachés is more important.

The greatest obstacle to the practice of medical asepsis is human indifference to underlying principles. We all know that these may be violated without ill effect in many instances, but we never know which violation may result in a cross infection. Because of this knowledge too many people are willing to gamble on the statistical chance that their errors will produce no harmful results. In the field of surgery no one would think of passing from one operative case to another without proper preparation between cases. Such an offense against proprieties in an isolation unit may have consequences which are just as serious, perhaps even more so, but the fact remains that rules of medical asepsis are difficult to enforce. Constant supervisory vigilance is required.

Single Rooms Simplify the Technique

Contagious diseases are transmitted commonly by direct or indirect contact. Air transmission is considered of little practical importance. This must not, however, be confused with droplet infection in which patients suffering from contagious disease transmit the disease by talking, coughing or sneezing directly into the faces of companions or attendants. Certain diseases are transmitted by inoculation. Examples of these are malaria and probably erysipelas. The causative organisms or viruses of contagious diseases usually enter the body through the nose or mouth, being conveyed to these portals by the hands or by direct contact, as in kissing. On the basis of our knowledge of the methods of transmission of these diseases we have over a period of years elaborated a method of caring for them safely by employing well defined principles of asepsis.

Medical asepsis is designed to break at its source the chain of events that leads to the dissemination of disease. Through its use it is possible to confine a disease to a physically separate unit by interrupting contacts, either direct or indirect, with this unit. One or more patients suffering from the same but no other contagious disease may be cared for in this area at the same time. Under proper precautions more than one unit may be designated in the same ward or room.

The necessary technique involved in applying the principles of medical asepsis may be carried out anywhere in the hospital, but a quiet section

*This article is one of the Hospital Organization series, under the direction of Dr. Winford Smith.

of suitable size, in a part which can be more or less segregated and which lends itself readily to isolation purposes, will serve best. Single rooms are best adapted to the work because they simplify the technique and give greater flexibility in handling different kinds of cases. If there are individual bathrooms so much the better, because these may also serve as individual utility rooms and more complete care may be given without leaving the unit. Running hot and cold water in each unit is highly desirable. Storage space for such clothes and utensils as may be needed in the care of the patient is a great convenience. Scrubbing and gowning facilities in the corridor or in an alcove just outside the patient's room give a sense of security that is not available when these activities must be carried out inside the room. Children cannot always be relied upon to observe carefully the restrictions imposed upon them in regard to "untouchables" and the majority of this class of patients are children, hence the difficulty when scrubbing and gowning facilities are placed inside the room.

Open Wards Require Strict Supervision

When single rooms are not available, the cubicle may be used to advantage. It should be of sufficient size to permit attendants to minister to the patients without crowding. It should be so constructed that it offers a minimum of interference with cleaning activities and ventilation. If partitions are built partly of glass, supervision is easier and juvenile patients particularly will be more contented because they will be able to see and talk to their fellow patients. If neither single rooms nor cubicles are obtainable, patients may be cared for in open wards. In this event, a minimum of five feet of space must be allowed between beds and careful attention must be given to the proper grouping of patients on the basis of susceptibility to the various diseases which are being cared for in the ward. The task of maintaining a strict aseptic relationship between patients is much more difficult in open wards than it is in rooms or cubicles because the human element is not sufficiently trustworthy. Obviously the closer we approach ideal accommodations the better our results will be, other conditions remaining equal.

Room Furnishings Should Be Simple

In a contagious section it is well to have the doors and corridors wide enough to facilitate easy movement of patients from one room to another without removing them from their beds. As a further aid to this interchange of patients the beds should be equipped with a good grade of caster so that they may be rolled easily. The rooms or wards should be furnished in the simplest possible fashion, everything in them, including the walls, being of a character that will permit frequent disinfection by sterilization or scrubbing with soap and water without undue deterioration. A minimum of storage space for the things that the patient brings with him is necessary for the reason that these things are restricted to the lowest possible minimum. In other respects the accommodations for contagious diseases need differ little from those designed for the accommodation of general hospital patients.

Organizing a Contagious Division

When the organization of a contagious division in a general hospital is contemplated, one of the first tasks is to employ a competent individual to plan the general and detailed operation of the section. The technique varies in different hospitals according to the physical characteristics and equipment of each institution. All properly managed contagious hospitals have their own manuals of technique in printed or mimeographed form and these are usually available for the asking. A number of them should be obtained and used as examples in building up the technique for a new unit.

Such manuals should be carefully reviewed and revised at frequent intervals, thus ensuring constant improvement. They convey to the reader and student definitions and descriptions of aseptic technique and of what it is intended to accomplish through its use. They also describe all procedures in detail and are the basis for teaching programs and demonstrations. It is the duty of the supervisor or director who is engaged to visualize and plan the work and then make up the manual of procedures and regulations. After this it is his duty to enforce the principles of asepsis with an iron hand.

The area set aside for the housing of contagious diseases is divided into "contaminated" and "clean" areas. These terms have reference to the presence or absence of the pathogenic materials of contagious diseases. All floors and all areas and things that have been in direct or indirect contact with patients suffering from contagious diseases are contaminated. Unless otherwise designated, this term applies to everything in a room or ward where patients are housed. Where patients are restricted to their respective units as they should be, all other areas and things may be considered "clean," except floors and the things that are carried from the units, such as personal effects of patients, laundry, dishes, garbage, utensils and similar items.

Doctors, nurses and attendants may enter con-

taminated areas without preparation, provided they touch nothing in the contaminated section except the floor with the soles of the shoes. If they are to come in close contact with the patient or with anything in the contaminated area, they must prepare themselves in such manner that they will not carry disease producing organisms to or from the patient or his unit.

A Poor Mask Technique Is Worse Than None

The commonly accepted method of achieving this purpose is as follows: a cap covering the hair and a mask covering the nose and mouth are put on. The hands are then thoroughly scrubbed, including any portion of the forearm which will not be covered by the gown. A surgical gown is then donned to cover the clothing. At the conclusion of the visit to the patient, cap, mask and gown are removed and the hands are thoroughly scrubbed. The same gown may be used over and over again for the same unit provided it is folded carefully with the clean side out and hung in a clean area set aside for that purpose, or folded with the contaminated inside out and hung in its place in the contaminated area. It goes without saying that when this is done the hands must be scrubbed before removal of the gown so that the latter act may be accomplished without contamination of either hands or gown. A poor mask technique is worse than none. The mask should never be touched with contaminated hands. If the mask slips down from its intended place, it should be discarded because the inner surface of the mask has thus become contaminated.

Hospital Attendants Should Be Immunized

The details of serving meals, administering medicines and biologicals, admitting and discharging patients, keeping records, making beds, housekeeping, in short, all activities having to do with proper handling of patients with contagious diseases, must be made matters of special concern and study in each institution and incorporated in the manual of regulations and procedures of the institution.

All of the accepted forms of immunization against contagious diseases should be used for the benefit of hospital attendants of all grades. Toxin-antitoxin, vaccination against smallpox and typhoid inoculation have values in the prevention of these diseases which are too well known to be overlooked when the protection of the personnel is considered. Where student nurses, interns and others are rotating through the contagious service, they should receive the benefits of these prophylactic measures sufficiently early so that immunity will have been acquired when the time comes for them to be assigned to the hospital's contagious disease section.

Visitors to patients ill with contagious diseases represent a somewhat different problem from that presented by visitors in a general hospital. To begin with, visiting is much more restricted, which means that the giving out of condition reports to relatives and friends and in general the maintenance of the patients' contacts with the outside world, place a much heavier burden on the attending personnel and particularly on the telephone operators. This must be kept in mind in making up duty assignments. Relatives may be permitted to visit from the corridors at intervals or even regularly without serious embarrassment to the service. If they are permitted in the rooms or wards, they must observe the details of technique and a considerable amount of nursing time is used in giving instructions to visitors and watching them for breaks in technique.

Cost of Operating Contagious Unit

The cost of operating a contagious disease unit is somewhat higher than that of operating a unit of similar size and comparable activity in the general hospital. The ratio of ward personnel to patients is increased, considerable time being consumed by the additional details involved in nursing and medical procedures. Greater quantities of linen are necessitated by the technique involved. General maintenance work is increased by the harder usage to which the unit is subjected. Training of personnel is a considerable item in operating a contagious disease unit.

The attention that is being given to the question of caring for contagious diseases in the general hospital is further evidence of the fact that hospitals are never static. They are constantly growing and changing in response to the medical conceptions of the changing needs of the sick. I cannot suppress the feeling that the hospital of the future will find a wider field for the application of the principles of asepsis than that which exists today. Perhaps a combination of strict surgical asepsis with thoroughly reliable medical asepsis is the answer to the problem of maternal mortality that confronts the hospital and medical professions in dealing with puerperal women. Already tuberculosis sanatoriums are exhibiting a marked tendency in the direction of employing a strict aseptic technique in handling their patients. The general hospital which is alive to these changes and possibilities and which equips itself to receive a wider variety of patients through the adoption of technique that will enable it safely to care for them, will find an increasing demand for beds in the institution.

Augustana Hospital.

Presbyterian Hospital.

The Keeley Pavilion, Passavant Memorial Hospital, is an architectural novelty. One wall is covered by unique mirror panels, on which ultra-modern decorative motifs have been etched.

Municipal Tuberculosis Sanitarium.

Meyer House, Michael Reese Hospital.

What Hospital Visitors May See in Chicago

CHICAGO's distinguished position as a medical center is being further enhanced by the fact that A Century of Progress is bringing to the city leaders in medical and hospital affairs from all parts of the world.

Outstanding institutions in this famous medical center are four university medical schools and their interrelated hospitals, the libraries and other reference material of the American Medical Association, American College of Surgeons, American Hospital Association and various other national organizations which carry on their work in this city for the benefit of the entire country.

Large general and special hospitals are strategically placed in every part of the city. Chicago's 113 hospitals have accommodations for 19,066 patients. An investment of approximately $95,325,000 is represented by facilities, and the annual budgets of these hospitals exceed $34,795,000. Many excellent smaller institutions serve the neighborhoods. Evanston, Oak Park and other suburban districts have institutions that would do credit to larger cities.

Short tours suggested for the Chicago visitor who wishes to make a cursory inspection of some of the city's medical institutions are:

A trip to the lower north side including the Northwestern University Medical School and Passavant Memorial Hospital, the American Hospital Association, the American College of Surgeons and the John B. Murphy Memorial and the American Medical Association headquarters.

A visit to the Midway, several miles south of the World's Fair Grounds and the site of the extensive medical center of the University of Chicago—a graduate school of medicine and five modern hospitals. A trip to the west side medical center where the visitor will find a group of general and special hospitals and two medical schools—the University of Illinois College of Medicine and Rush Medical College.

Visits should also be made to the medical libraries, most of which are maintained in the medical schools and larger hospitals, including those of the American Medical Association, American College of Surgeons and John Crerar Library Department of Medical Sciences. The most complete literature and reference material on hospitals to be found anywhere in the world is available at the Hospital Library and Service Bureau of the national association.

The bronze doors on the front of the John B. Murphy Memorial building of the American College of Surgeons, shown at the top of this page, are considered by art experts to be among the finest in the country and compare favorably with the historic doors on Trinity Church, New York City. The subjects of the six panels that adorn the doors are: Æsculapius, the god of medicine; Pasteur, a founder of science: Osler, a great clinician; Lister, the father of modern surgery: McDowell, an American pathfinder in surgery, and Gorgas, a world sanitarian.

The two top panels are those of Æsculapius and Pasteur, the center two are those of McDowell and Lister, while the bottom two are of Osler and Gorgas. There are two ornate bronze lamps, one at each side of the door.

Many architects from all over the country have visited the building since its completion and have expressed their admiration for its design. The plans were drawn by Marshall and Fox, Architects, Chicago.

Someone Has Asked—

What Authority Should Visiting Physicians Have in Selecting Staff Members?

That members of hospital boards have no way of becoming informed as to the ethics and professional adequacy of applicants for staff places is often contended. This claim is in a large measure well founded. Physicians also contend that no staff member should be elected unless he is approved by the medical group in committee or as a whole. This claim may be correct in principle but in practice it is of questionable wisdom.

When the election of staff members is placed in the hands of physicians, institutional politics thrive and the morale of the physician group deteriorates. The surest way to create cliques in a visiting staff is to permit the election of new members wholly on the basis of the recommendation of doctors. A staff group known as the qualification committee may be formed and names of applicants may be submitted to this committee for an opinion. This is the only prerogative that should be granted to staff committees.

A wise board of trustees will carefully consider the wisdom of electing a new staff member over the protest of the visiting group as a whole, but under the present hospital set-up physicians should be given only recommendatory powers.

Who Should Comprise the Out-Patient Department Population?

Some persons believe that patients who can pay anything for out-patient care should be referred to a physician's office. Others have endeavored to set a minimum fee, such as 25 cents or 50 cents, as the dividing line separating dispensary patients from those who should see a private physician.

It is difficult to arrive at any equitable basis of differentiation. Some persons who willingly pay 50 cents for a dispensary visit are actually depriving themselves of food in order to pay this fee. Others who just as readily pay this amount are able to meet the fee of a private physician at several times this figure. Careful case work is necessary in order to differentiate between the imposter and the worthy applicant for dispensary care. It is far better to err on the side of the patient than to permit an injustice to be done to a man or woman without funds. On the other hand, care should be taken to prevent those who are able to meet the fee of a private doctor from receiving care at a minimum figure.

Caution should be exercised not to form snap economic judgments based solely upon the appearance of the patient. Chronic dispensary habitués may be referred with justice to a municipal or state dispensary or to a private doctor. It is folly to endeavor to determine a patient's ability to pay without a thorough knowledge of family income and expenses. On the other hand, it is unfair to the patient to permit him to pauperize himself even though he is willing to do so.

Should the Training School Committee of the Staff Discipline Nurses?

Long and arduous preparation is necessary on the part of the superintendent of the nursing school. She must possess administrative ability and a keen sense of disciplinary fitness and fairness. Her policies must be so formed that pedagogic as well as institutional needs are met.

No school can be properly conducted when authority is divided. Staff physicians may fully understand the medical needs of their patients. They should and do know good nursing when they see it. The training school staff committee should serve in a liaison capacity to harmonize bedside nursing and the pedagogic and administrative practices and procedures which make it possible. No physician should discipline a nurse in the presence of others. Unless lines of authority in this matter leading from the physician to the directress of the school of nurses are carefully observed, institutional chaos in the training school will result.

The superintendent of the school may well consult such a committee as to general policies and in certain instances request advice as to disciplinary needs. This committee, however, should have but an advisory function. No training school committee should have authority to discipline nurses. The directress should be upheld in this matter and she alone should directly mete out discipline to pupils or other nurses who deserve it.

Who Should Get Free X-Ray Service?

The x-ray department is one of the hospital's most expensive specialties. When cost of plates, personnel salaries, heat, light, electricity and deterioration of apparatus are computed on the basis of an individual exposure or series of films, the expense per patient of conducting this department is far from nominal.

Since the director of the x-ray department is in most instances engaged on a percentage basis, he is directly concerned with the size of the free load which his department carries.

It is usually assumed that the hospital and the director of the x-ray department shall share equally in carrying the free ward and dispensary load. In some institutions ward patients pay a minimum fee for x-ray service; in others no charge is made. Sometimes dispensary patients are charged a fee; again they are not. Members of the hospital personnel living within the institution are usually studied without expense to themselves. Members of the hospital staff are sometimes given free service with half rates for their families. In other instances staff members and their families are both granted a 50 per cent reduction. Members of the courtesy staff are sometimes given a substantial reduction in x-ray fees when they or their families require this service.

It seems to be good business to make substantial reductions for personal services to staff members, although no favoritism should be shown. When student nurses in a large training school are ordered to have x-ray pictures made frequently, as a preventive medicine measure, this expense should be borne wholly by the hospital rather than divided equally between the institution and the director of the x-ray department. Free service should be given only to those who are unable to pay or to physicians who serve on the visiting staff of the hospital.

If you have any questions to ask, the editor will be glad to discuss these in a forthcoming issue

A Flat Rate Payment Plan That Is Working Successfully

Initiated more than a year ago, the flat rate system used at Evanston Hospital, Evanston, Ill., has won the approval of doctors, patients and the hospital. While the hospital still considers the plan an experiment, yet it is a fact that the first upturn in earnings in many months came soon after the flat rate was adopted

By ADA BELLE McCLEERY

Superintendent, Evanston Hospital, Evanston, Ill.

THE favorable reaction of doctors and patients and the satisfactory results it has produced for the hospital make the flat rate payment plan used at Evanston Hospital, Evanston, Ill., a subject worthy of study by other hospitals. The system has been in effect at the Evanston institution for more than a year. The inauguration of the experiment was preceded by a lengthy and exhaustive study of patients' attitudes and patients' bills. What follows is an account of the inauguration and progress of the plan.

We had never given much thought to the importance of the patient's attitude toward his bill. If our thoughts had been put into words they would have expressed our conviction that hospital charges were more or less uniform and that the patient should meet his hospital bill in the same manner he would meet any other unexpected expense. But the wide publicity given to medical costs made us realize that the correct attitude of the patient is tied up with a consciousness, on his part, of fairness in all financial dealings. Not that all of the publicity was fair—some of it aroused our ire—yet perhaps its unfairness strengthened our determination to clarify the relationship between institution and patient in Evanston Hospital and to find, if possible, the underlying consideration in this new fashion of criticism of the cost of illness.

For criticism had become the fashion. No longer were doctors and nurses regarded as angels of mercy, or hospitals as havens of refuge; but, according to the public press, the three had conspired in an effort not only to empty the pockets of the patient but also to mortgage the resources of his family.

In order to find out more about this relationship between hospital and patient we decided to make a study of it. Since we were to confine the study to an individual hospital it was necessary to settle upon some point at which to begin. Accordingly we began with patients' accounts, keeping in mind three things: analysis of accounts, complaints about accounts and the reaction of the group paying without protest.

First, all accounts for a period of six months were investigated, room and board being separated from special charges. The accounts were thus individualized. A review of thousands of individual accounts causes a hospital executive to change his point of view. He sees operating room and x-ray fees in the same light as the patient instead of as a statement of earnings. The grand total of special charges, or extras, for the individual patient gave the superintendent a feeling of chagrin and a desire to hide under her desk. If the reaction of the patient paying without protest was similar, one discovery, at least, had been made.

Extra Charges Act as an Irritant

Assuming that the attitude of this group had been disclosed, the hospital authorities were led to a second conclusion: that practically all complaints were associated with the fees for extras. If this were true, it seemed natural to assume that special charges, or extras, act as an irritant because they are beyond the control of the patient.

The room and board charge is the only charge under the control of the patient. After deciding upon the type of accommodation desired, the patient is subject to the doctor's orders for whatever may be necessary in the way of diagnosis and

treatment. The jolt comes when the bill is presented. And, because it is the hospital, not the doctor, that collects this swollen bill, its collection may cause strained relations between the hospital and the patient.

The more we studied this complex situation the more we wondered if the practice of passing on to the consumer both the cost of technical equipment and the expense of the personnel necessary for its operation were justified. We could see no other method for meeting this expense except huge endowments, since both the original investment and the upkeep required cold cash. The question then was to find some means whereby misunderstanding might be eliminated and good will fostered, without the hospital's making too great a financial sacrifice.

From the beginning our thinking had been stimulated by the many references heard in hospital meetings in regard to a flat rate charge. We had reached the point where such a plan seemed desirable, although we were not convinced that it was feasible. We made an estimate of what our income would be if we abolished all special charges and increased the per diem rate. This estimate was presented to the executive committee of the board of directors, who discussed it with interest but postponed action. However, some good seed must have been sown for when the proposition was again submitted about two years later, together with a recommendation that the plan be undertaken as an experiment, it was accepted.

The Increases in Rates

The plan was simple. All patients, whether in a ward or in a private room, were to be given any service, special nursing excepted, that the attending doctor considered necessary without extra charge. The increases in rates were as follows: beds in the contagious disease department $0.50 a day; all other beds $2 a day except for the new born, no increase being made for this group. The minimum fee for tonsilectomies was fixed at $10.

When the experiment was initiated there was no attempt to gain publicity through the public press. For information only, a letter explaining the plan was sent to every doctor who used the hospital, stating that an experiment which might be terminated at any time was being undertaken.

When the plan was inaugurated it was felt that six months would prove whether it was a success or a failure, but at the end of that time general conditions were so abnormal as to make it impossible to draw fair conclusions. There was, however, abundant evidence that the plan had met with the favor of both patients and doctors. Because of this it was decided it would be unwise to change the policy without further study and a longer period of experimentation.

The first year of the experiment ended on April 30, 1933. At that time, in order to determine the actual results of the experiment, a thorough study was made of five hundred accounts. These accounts were selected at random. Care was taken, however, to have all departments of the hospital as well as a large number of doctors represented. The study covered accounts for both adults and children, and practically all branches of medicine were represented. Seventy different doctors were "at the helm" of the five hundred accounts.

The Old Rate Versus *the New*

From the first, two bookkeeping records had been made for each patient; one, covering the day's care, was sent to the patient; the other, covering all special services at the former extra charge, was kept for the hospital's information. This method added greatly to the bookkeeping load, but it made conclusions specific and informing.

"Profit" or "loss" as used in the following paragraphs has no reference to actual cost but is merely the result shown when the old rate is compared with the new. For instance, under the old rate Patient A, who was in the hospital for twelve days, was billed for twelve days at $4 a day. The charges for special services, however, were as follows: laboratory, $3; x-rays, $25; operating room, $10, and anesthetic, $10, or a total of $48 for special services, making his total bill $96. Under the new rate Patient A was billed for twelve days at $6, or a total of $72. Thus, the patient saved $24 and the hospital suffered a "loss" of the same amount.

Of the 500 accounts analyzed, 452, or 90.8 per cent, showed a hospital "loss" and a patient "profit" of $11,558.38. These "losses" ranged from $0.05 to $177.15, the average being $25.57. The hospital "loss" was more than $100 in 1.4 per cent of the accounts. The minimum hospital "loss" was $107.31 and the maximum was $177.15.

Although 2.6 per cent of the accounts had special charges of less than $5, in 4.2 per cent of the accounts the special charges were over $100, the highest being $343.31. This was the largest account of the 500 studied. The patient was hospitalized 106 days at $9 a day, making a total of $954. The hospital "loss" amounted to $131.31. The patient tapped all of the resources of the hospital, not once, but many times.

The hospital "profited" in only forty-eight instances, or in 9.2 per cent of the accounts studied. The total "profit" was $591.27, as compared with a "loss" of $11,558.38. These "profits" ranged from $0.25 to $59.74, and averaged $12.31. In 89.5 per cent of the accounts studied the "profit" was under

$25 and in 60 per cent of the accounts the "profit" was under $10.

The greatest number of days spent in the hospital by any one patient was 106. The average hospitalization was 10.14 days, although 20 per cent of the group had a stay of one day only. The smallest account was $4.50, and 6.2 per cent of the patients had accounts of less than $10.

Two things should be taken into consideration in reviewing the experience of Evanston Hospital: first, the equipment for special services is already installed, and that since the personnel is not usually required to work to capacity the only actual extra expense is the cost of the supplies used; and second, it is impossible to determine how many of the patients entered the hospital because of the rate revision. At all events, the first upturn in earnings in many months came shortly after the experiment began, and, although April, 1932, was on the old plan and April, 1933, on the new, the earnings were greater for the latter month. The hospital authorities still refer to the system as an experiment because they believe that it will take a longer period of time under more normal conditions to prove its worth.

The doctors like the plan because they are not restricted in the use of aids in studying and treating a patient. Several members of the medical staff have expressed their personal appreciation. The doctors have cooperated well. Although certain services have been utilized which probably would not have been used if the patient were required to pay an extra fee, sound judgment has been used by the doctors in ordering extras. Only in isolated instances has unfair advantage been taken of the privilege. Tribute is due to the high honor of the hospital's physicians and surgeons.

Patients approve the plan. Their approval is based upon the fact that the cost hurdle is taken in one leap, rather than upon the specific rate per day. There is still a steady demand for the hospital's best accommodations, as well as for those available at popular prices. One patient expressed his approval as follows: "I believe the change was the wisest thing the hospital ever did. It is a great satisfaction to know just what one is really paying for hospital services."

The hospital likes the flat rate plan because it gives the patients a square deal and because complaints seldom are received regarding an account. We believe that the finest thing of all is the good will that is being built up in the community.

Lack of Specific Instructions Does Not Void Bequest

A testamentary trust created by a will directing the trustee to distribute the residue of the testator's estate "to the patients in Walter Reed General Hospital," Washington, D. C., and providing that "the worst cases" shall "receive the most money" and that "the other patients" shall "receive so much in regards to their ailments," is not void for uncertainty and impossibility of fulfilment.

In an action by the testator's heir at law to have the bequest declared void, the trustee in his answer stated that he was "willing and desirous of carrying out" the provisions of the will, but because of the number and type of patients at the hospital, as shown by the report of the surgeon general of the army, he was "unable to make distribution of the funds in hand in the absence of specific directions and instructions" from the court. The average number of patients at the hospital is about 1,000, composed of officers, enlisted men, civilian veterans' bureau beneficiaries and civilians.

The trust constitutes a charitable trust within the rule that such trusts are favorites with courts of equity and will be sustained and enforced notwithstanding indefiniteness and uncertainty if the general nature of the trust is so described that the trustee may administer the trust under the superintendency of a court of equity. The general nature of the trust was the relief of patients in the hospital at the time of distribution.

The fact that the amount to be distributed to the individual patient may be comparatively small is of no consequence for the principle is the same whether the amount be large or small. The intention of the testator, although expressed in artificial language, was to clothe the trustee with discretion in the administration of the trust to favor those patients who most need assistance. In view of the charitable use, the vesting of such discretion in the trustee did not invalidate the trust. Darcey *vs.* O'Brien, trustee, etc.; D. C. Ct. Appls., No. 5611, May 1, 1933. (Robb, A. J.)

How Many Supervisors Does the Hospital Need?

The supervision provided for the ward from the central nursing office will depend considerably on the size of the hospital and its general plan of organization. In a hospital of fifty beds, the superintendent of nurses, or her assistant if she has one, may act as supervisor, according to the findings of the National League of Nursing Education in its study, The Use of the Graduate Nurse for Bedside Nursing in the Hospital.

In larger hospitals one supervisor or more may be assigned to the surgical service. One supervisor for every 75 to 100 patients during the day is suggested as a possible ratio. Even though the ward is staffed with graduate nurses and has a graduate head nurse, the importance of central supervision should not be minimized, the study points out. It is an additional guarantee to the hospital that the nursing service is administered economically, that patients receive consistently good nursing care, and that a coherent and practical program of staff education is carried on. Such a program should provide stimulation to the worker and enable her to see the creative possibilities in bedside nursing, the study concludes.

Careful Estimates of Needs Vital to Group Payment Plans

By HOMER WICKENDEN
General Director, United Hospital Fund of New York

ACTUARIAL and statistical studies are the foundation stones of insurance companies. The soundness of their policies depends primarily on such studies and the apparently strong company that neglects this feature of its work is the one that is likely to fail.

The same may be said of group payment for hospital care. If hospitals and group hospitalization plans are not going to be carried out beyond their depth they should avail themselves of the best actuarial help they can get and make a special effort to aid in the accumulation of statistical material for judging the soundness of such plans.

In working out plans for the development of group hospitalization, it is easy to assume that only 6 or 7 per cent of an employed group will require hospital care in a year. But have we enough information to be sure? Will the average hospital stay for subscribers to such a plan always be about nine days?

Dr. Michael M. Davis, Chicago, reporting on the costs of medical care at the 1932 meeting of the American Hospital Association, stated that "about 6 per cent, or one-sixteenth, of the population require hospital care during the year." The Committee on the Costs of Medical Care found in a

TABLE I—STATEMENT OF PROGRESS OF THE HOSPITAL SAVINGS ASSOCIATION OF LONDON AND STATISTICAL REVIEW FOR THE FIVE YEARS, 1928 TO 1932, INCLUSIVE

	1928	*1929*	*1930*	*1931*	*1932*
PROGRESS					
Number of groups at 31st July	5,128	6,711	7,986	8,786	9,503
Number of contributors at 31st July	449,173	651,713	810,144	929,480	1,027,808
Amount of contributions during the year	£242,938	£320,787	£438,354	£516,415	£578,214
HOSPITAL EXPERIENCE					
Average number of days per in-patient	23.23	23.62	23.1	23.27	22.73
Average number of days per in-patient (cooperating hospitals)[1]	21.48	21.27	20.58	20.35	19.90
Average number of days per in-patient (poor law hospitals)[2]	27.46	28.89	28.92	30.11	29.46
Incidence[3] of in-patients					
(a) Contributors only	7.69%	8.45%	8.71%	9.01%	9.38%
(b) Contributors and dependents[4]	3.85%	4.22%	4.36%	4.50%	4.69%
Voluntary hospitals	5.32%	5.8%	6.06%	6.32%	6.60%
Poor law hospitals	2.37%	2.6%	2.65%	2.69%	2.77%
Incidence[3] of out-patients					
(a) Contributors only	27.24%	26.91%	26.91%	26.13%	25.45%
(b) Contributors and dependents	13.62%	13.45%	13.45%	13.06%	12.72%
GENERAL					
Total contributions	£242,938	£320,787	£438,354	£516,415	£578,214
Mean number contributors	405,660	528,502	730,928	869,812	978,644
Average contribution per contributor	11s. 11.5d	12s. 1.6d.	11s. 10.9d.	11s. 10.5d.	11s. 9.8d.
Number of effective vouchers issued					
(a) Hospitals	131,757	172,407	238,929	279,625	310,229
(b) Extra hospital benefits	50,607	66,281	103,340	130,038	142,523
(c) Refunds (including poor law hospitals)	24,268	29,948	39,746	43,652	46,759
	206,632	268,636	382,015	453,315	499,511

[1]Cooperating hospitals are voluntary hospitals on the list of the association.

[2]Poor law hospitals have, since April, 1930, been transferred to the county council and are now known as county council hospitals. They are rate-aided institutions.

[3]The incidence is the proportion which the total number of cases treated bears to the mean number of contributors or to the mean number of contributors and dependents (latter estimated).

[4]It is assumed each contributor has one dependent. Probably this is an underestimate. No record is kept of the number of dependents.

study of 38,668 white persons in 8,639 families that the number obtaining hospital care ranged from 6.5 to 7.4 per cent for families with incomes of less than $5,000.

Preliminary studies for the Hospital Council of Essex County, New Jersey, made by Frank Van Dyk, revealed that 10 per cent of the population of that county used the hospitals and that the gainfully employed persons using the hospitals constituted only 7 per cent of the total population.

Figures collected for the past ten years by the United Hospital Fund of New York show that between 9 and 10 per cent of the population of New York City use the hospitals annually. These figures, however, include chronic, tuberculous, pediatric and some other types of patients, employed and unemployed alike.

Sickness and death rates for communities vary and it is logical to suppose that rates of hospitalization should vary. Some of the elements that appear to affect the rate of utilization of hospitals are (1) living conditions in the community; (2) general economic conditions; (3) geographical location; (4) number of hospitals and hospital beds; (5) ease or difficulty of getting free hospital service; (6) training and attitude of the doctors; (7) racial and national make-up of the population; (8) nature of the industries in the community, and (9) epidemics.

What percentage of the subscribers should we estimate as likely to require hospital care in an average year? Shall we figure on 6, 7, 8 or 9 per cent? This is one of the most important questions to be answered by any group preparing to establish a group hospitalization plan. Insurance authorities warn that increased utilization by subscribers is to be expected as the plan develops and that subscribers are likely to demand more service as they become more familiar with the plan.

The reader may wonder why there is so much concern over the small matter of a possible 3 per cent variation. If it were merely an academic discussion of whether to use the 6 per cent or the 9 per cent figure, no one need be much concerned. But that 3 per cent, when translated into dollars and cents, may mean the difference between the success or failure of the plan. Careful estimating in advance may save the hospitals a deficit and avoid the necessity of raising the rate to the subscriber, a procedure which is disheartening.

If the plan is developed successfully, the sale of memberships in New York City ought to reach at least 100,000 a year. If 7 per cent of the members are hospitalized in a year for an average stay of 12 days—the average stay in general hospitals in New York is 12.6 days—the central office of the group hospitalization plan would have to reimburse the hospitals for 7,000×12 days, or 84,000 patient days. If, on the

Group Hospitalization in England

The Hospital Savings Association of England is a successful example of group hospitalization. The organization comprises a group of contributors, either fellow employees or members of a Friendly Society or other group, with a secretary who acts as a link with the association. The secretary issues vouchers to eligible contributors for presentation at any hospital on the list of the association. These vouchers are accepted by the hospitals in lieu of payment. The hospitals are paid quarterly out of the contributory fund on rendering a report of H.S.A. out-patient and in-patient services.

Many employers encourage the plan by providing for pay roll deductions with the employees' consent and by offering administrative assistance. Some employers add one penny a week to the three-pence contributed by the employee. The national conference of Friendly Societies has recommended that its constituent societies encourage the plan. The Friendly Societies are particularly helpful since they enroll contributors who cannot be grouped in their place of employment.

Payments by the H.S.A. go largely to voluntary hospitals, but some payments are made to tax supported hospitals for services to members, and some members are reimbursed for services which they have received and paid for in noncooperating voluntary or governmental hospitals. Dentistry and ophthalmology are also covered. Management expenses are now substantially less than 10 per cent of the contributions.

In spite of general economic distress, the H.S.A. has grown steadily since its organization in 1922 by a grant of £25,000 from the King Edward's Hospital Fund. Largely through its efforts the income from patients of the voluntary hospitals of London has passed £1,000,000 a year.

other hand, 9 per cent of the members were hospitalized for 12 days the hospitals would have to be reimbursed for 108,000 patient days—a difference of 24,000 patient days. At $7 a day, the rate at which the New York committee hopes the hospitals can ultimately be paid, this difference would amount to $168,000.

In this instance a variation of 2 per cent is not a small matter and failure to make careful estimates in advance might result in the accumulation of a deficit or prevent the building up of necessary reserves.

TABLE II—HOSPITALIZATION STATISTICS FOR MERSEYSIDE HOSPITALS COUNCIL, LIVERPOOL

Type of Hospital	*Estimated Number of Contributors and Dependents Entitled to Privileges*[1]	*Number of Contributors and/or Their Dependents Who Were In-Patients in Hospital*	*Percentage of Patients to Estimated Contributors and Dependents*
	1929		
Associated voluntary hospitals	547,500	12,590	2.31
Public assistance hospitals		7,548	1.38
Total		20,138	3.69
	1930		
Associated voluntary hospitals	639,215	14,485	2.27
Public assistance hospitals		9,481	1.48
Total		23,966	3.75
	1931		
Associated voluntary hospitals	689,132	15,230	2.21
Public assistance hospitals		8,600	1.25
Total		23,830	3.46

[1]Based on 2½ dependents to every contributor.

It may be that employees in carefully selected industries will require less hospital service than the average and that different rates may ultimately be worked out for different classes of workers. But it seems wise to make conservative estimates. Then if a surplus accumulates, after a reasonable reserve is put aside, the surplus may be used for the reduction of the rate to subscribers or to extend the benefits offered them. The experience of the Hospital Savings Association of London, as shown in Table I, is significant in this connection.

F. B. Elliot, general secretary of the Hospital Savings Association, comments as follows on the increase in number of contributors using the hospitals from 7.69 per cent in 1928 to 9.38 per cent in 1932:

"On the question of incidence of in-patient treatment, in any voluntary scheme like the H.S.A. selection will always tend to be against the scheme. Propaganda must be directed and regulations made in the light of this fact. I do not think that the H.S.A. has caused an increased in the demand for hospital treatment. There is a generally increasing demand for institutional treatment by the community at large, causes being the spread of knowledge, increased popularity of certain operations and the conditions of living in urban communities. . . . Should the conditions in New York be substantially similar to those in London, the figure of 9 per cent would, in my judgment, be a safe basis."

Hospitalization statistics for Liverpool, supplied by Sydney Lamb, secretary of the Merseyside Hospitals Council, are presented in Table II. A significant feature of both the London and Liverpool figures is the service which is being rendered to the various dependents of the subscriber or contributor.

The experience in London and Liverpool suggests that the next step in the extension of benefits of group hospitalization plans be the caring for dependents of subscribers.

If dependents could be included, it would multiply several times the number of persons benefited and greatly increase the number of persons who feel a personal interest in hospitals. The footnotes indicate that London estimates one dependent per subscriber, while Liverpool estimates two and one-half. In a city of 100,000 people, if 10,000 workers were enrolled in the plan, and two dependents for each worker were included, the number benefited would reach 30,000.

Hospitals can well afford to strive for such an extension of the benefits and privileges offered under their group hospitalization plans. Those hospital groups that pioneer in this field and accumulate accurate data on the rate of utilization by dependents and the added cost will render a great service to the movement.

Tumor Clinic in China Treats Many Patients

The first report of the Tumor Clinic of the Peiping Union Medical College has been forwarded to the American Society for the Control of Cancer by Dr. John W. Spies, department of surgery.

The clinic was established in February, 1932, along the lines approved by the American College of Surgeons. Since its opening it has reached a steadily increasing number of patients. Besides the regular staff, the clinic has the active cooperation of many specialists. It owns 600 mgs. of radium, three x-ray machines and an electro-surgical unit.

A Century of Progress Hospital for Emergency Cases

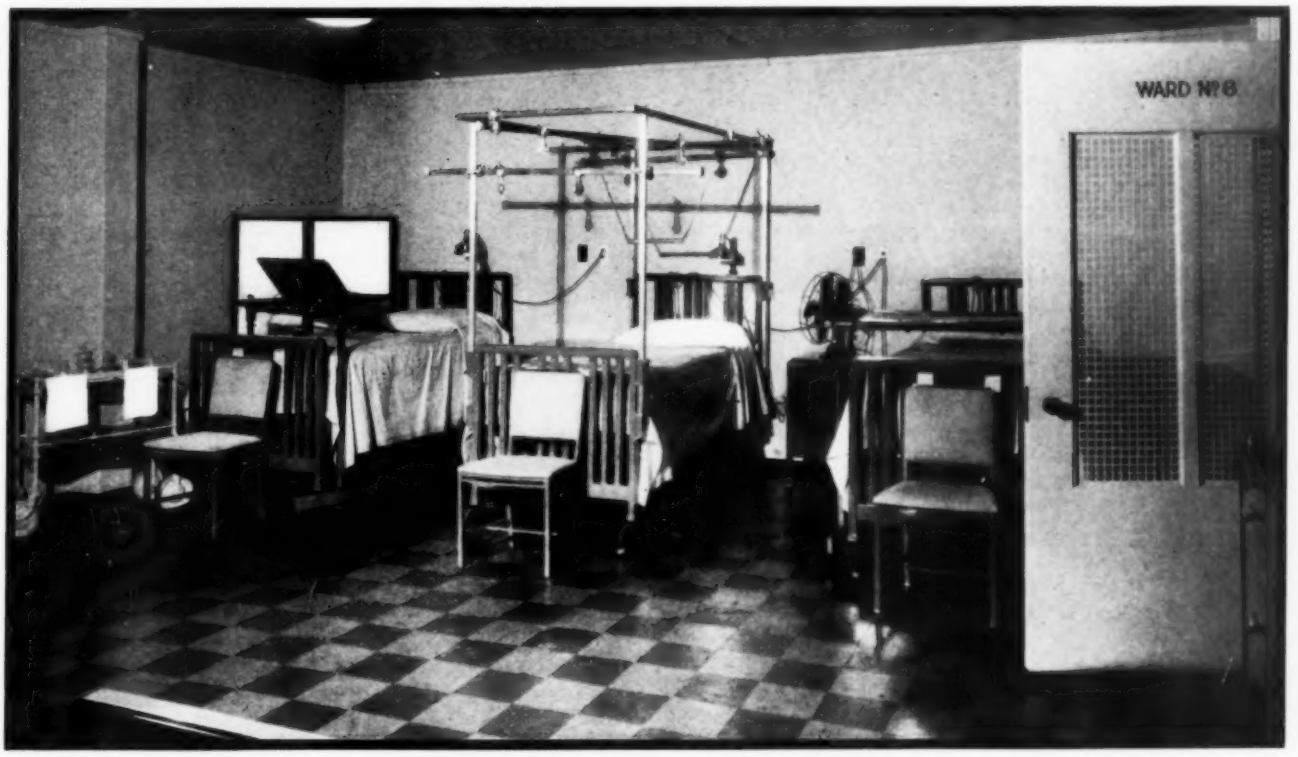
By CHESTER HART, B.Arch.
Chicago

A CENTURY of Progress Hospital, on the ground floor of the Hall of Science at the Chicago exposition, was established to care for emergency cases during the construction, operation and demolition of the fair. Although this emergency hospital is only temporary, no detail was slighted in its planning. The most modern equipment was installed to make it a complete hospital unit.

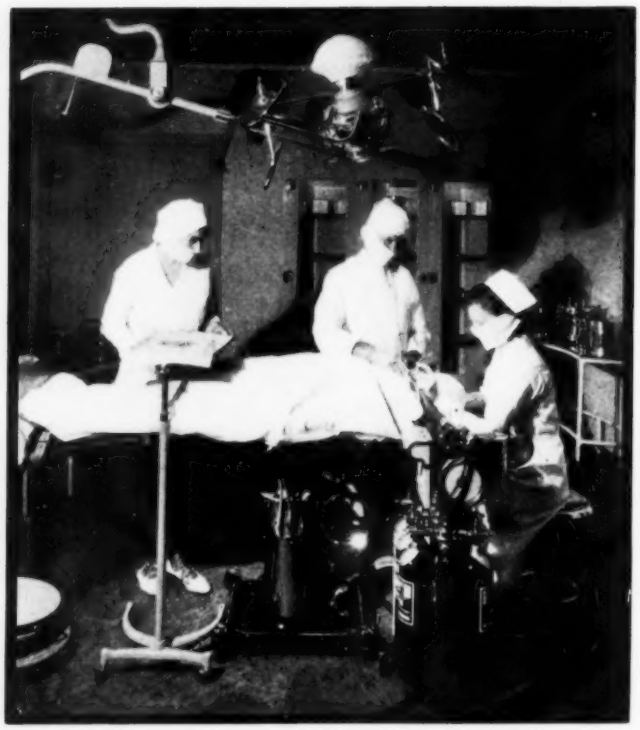
Facilities for the treatment of all probable accidents to workmen and employees as well as caring for the minor injuries that might occur to visitors had to be provided. No cases are held overnight, however, and patients requiring continuous hospitalization are transferred to local hospitals. The solution for some of the unusual conditions met in planning and equipping this hospital are interesting and worth investigating. The hospital is open for inspection by members of the hospital field, but it is not an exhibit for public inspection.

The hospital was designed by J. E. O. Pridmore, architect, and it is under the administration of Dr. F. W. Baylor, who has been in charge since the design was begun.

Beginning with what seemed to be serious handicaps, because the building structure was already erected, and the building requirements of A Century of Progress necessitated windowless rooms, many of these handicaps were turned to positive advantages. The plan is roughly Y-shaped with an ambulance and general entrance from the exterior, and one from the building corridor. Close to the ambulance entrance there is a small morgue, while farther down the corridor are the examination room, the reception room, the record room and the business offices. On the opposite side of the corridor are two noncommunicating surgical dressing rooms, one of which is connected to a completely



The six-bed ward contains one fracture bed, but otherwise is equipped with regular hospital beds, straight chairs, bedside tables and a dressing cart. There is also room for several stretcher carts in case of emergency.



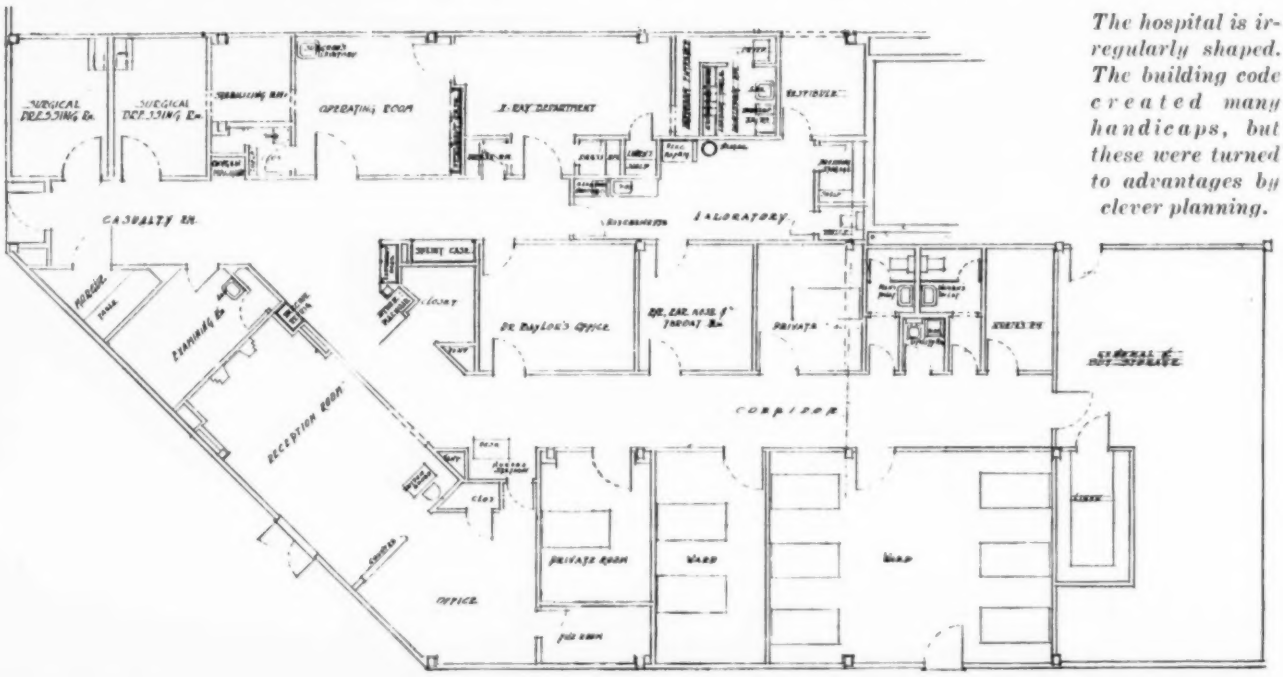
The operating room is fully equipped for the performance of major operations if immediate surgical treatment is imperative.

equipped operating room. Between these two rooms and communicating with them is the sterilizing room.

The operating room is equipped for the performance of major operations if immediate surgical treatment is imperative. The operating room is connected to the x-ray department, which includes a well arranged and completely equipped darkroom. Along the other leg of the Y corridor are the superintendent's office, the eye, ear, nose and throat room, the therapy room, two private hospital rooms, one two-bed ward and one six-bed ward. The corridors are wide enough to accommodate cots, should all rooms be filled to capacity, and there would still be plenty of room for the passage of stretcher carts. The toilets, the utility room and the linen room are near the hospital rooms.

The irregular shape of the space at the disposal of the hospital, and the location of columns and mechanical equipment made many small spaces that might ordinarily have been concealed within the hospital walls. These spaces, however, have been used to advantage for recessed cabinets and niches for the storage of supplies and equipment. A splint case in the corridor wall makes a dustproof and accessible storage space for these accessories. A recess near the entrance holds an oxygen inhalator in readiness for instant use, and another recess near the operating room contains an auxiliary ether machine. Similarly, a refrigerator for vaccines and an instrument storage case are recessed into the corridor wall. This goes to show that small spaces, which ordinarily are wasted, can be turned into useful storage accommodations which will facilitate service and produce a noticeable saving.

The use of color to brighten corridors and make windowless rooms pleasant is one of the outstanding features of the hospital. The corridors have a dark green and black tile pattern floor with a black cove base and border. The walls and ceiling are canary yellow, and the doors and trim are an oyster white. The reception room is decorated in the harmonizing colors of coral tan and henna red used



The hospital is irregularly shaped. The building code created many handicaps, but these were turned to advantages by clever planning.

in varying shades. A slight note of contrast is added in the emerald green upholstery used on two chairs. Modern metal furniture makes this a comfortable waiting room. In this hospital is illustrated that color, properly used, forwards the appearance of sanitation, and is actually soothing to distraught nerves.

The first private room has oyster white walls and ceiling, and a dark gray blue linoleum floor. The severity of the black and chromium furniture is relieved by the warm gray corduroy upholstery of the chairs. A striped bed covering adds a note of brilliant color. The second private room has

The reception room is decorated in the harmonizing colors of coral tan and henna red used in varying shades.

light coral walls and ceiling with a niche for the dresser, which is painted white. The floor is dark gray blue linoleum, and the furniture is a slightly darker coral than the walls. The furniture is trimmed with chromium. The two-bed ward has yellow walls and ceiling, and the furniture is a light blue green with chromium trim. The six-bed ward has light gray blue walls and ceiling and the furniture is blue, trimmed with chromium. This attention to color has made these rooms livable even without the usual window lighting.

The furniture is enameled metal with chromium trim, and is built along the simple straight lines and proportions of modern design. The private rooms are furnished with a hospital bed, a dresser, two small tables, an overbed tray, a bookrest, one straight chair, one lounge chair and a metal screen. The bed has an adjustable light fixture toward the left and at the top of the head board. The fixture consists of a short flexible connection, and a four-foot pipe extension to which is hinged another short pipe. The short pipe fits through a hole in the top rail and is used to hold the light when fully extended. The long arm may be swung horizontally in an arc, and it is used to illuminate the lower part of the bed for surgical dressings, and for applying heat treatments. The lighting fixture may also be completely removed from its anchorage. When used as a reading light only the flexible cable projects above the head rail.

A nurses' call button is beside each bed, and operates a small light in the corridor wall.

The walls and ceiling throughout are made of wall board to which paint has been applied. The operating room walls are covered with a thin linoleum composition wall material for ease of cleaning.

General illumination is obtained by recessed ceiling lights in reflectors. About two inches below the ceiling is suspended a circular translucent cover glass that spreads and diffuses the light.

The six-bed ward contains one fracture bed, but otherwise is equipped with regular hospital beds, straight chairs, bedside tables and a dressing cart.

There is also room for several stretcher carts in the ward room in case all the other beds are filled.

The operating room is equipped with a hydraulic operating table that allows practically every surgical position, a shadowless, deep penetrating, movable surgical light, an ether and nitrous oxide anesthesia machine, instrument and dressing tables, a knee operated surgeon's lavatory, a built-in instrument case, and in a closet just off the operating room is a surgical washup sink.

The sterilizing room is equipped with an ex-

The modern equipment of the x-ray department makes it possible to expose and develop plates in eight minutes.

posed type of direct steam sterilizer for instruments and dressings.

The x-ray department is equipped for fluoroscopic and x-ray examination. With the modern equipment and layout of this department an x-ray plate can be exposed and developed in eight minutes. The darkroom is directly connected to the x-ray room by a baffled entrance to allow easy access at all times. Along one wall of the darkroom are the loading shelf, the storage cupboards, the metal film storage and the red and white lights for illuminating activities on this side of the darkroom. On the other wall are the developing and washing tanks, the sink, the drying racks and the red and white lights for illumination. The lights have been arranged so that proper lighting may be obtained for any darkroom activity. There is a drying cupboard with forced ventilation just outside the darkroom in the entrance hall for use if speed is necessary in drying films.

There are a lavatory and a cabinet in the wall of each surgical dressing room, but all the other equipment is movable. A portable operating light and a light weight operating table are additional equipment in one of the rooms. Each of the rooms is fully equipped to take care of minor surgical dressings.

The portable operating light is another one of many pieces of new and unusual equipment installed in this hospital. This spot light has a reflector of sufficient diameter to minimize the head shadow which is usual with fixtures of this type. It is unique inasmuch as it operates through a transformer, automatic relay, trickle charger and battery, in such a fashion that the blowing of a fuse or the interruption of the main lighting service permits it to carry on through an entire night of emergency surgery.

Over 3,000 Cases in First Month

The therapy room is near the hospital rooms and contains a machine for inducing artificial fever. Body temperature may be elevated two to six degrees within thirty to forty-five minutes, and any desired body temperature can be developed and maintained over a period of hours. Recording dial gauges give the exact history of the machine's performance while the patient is being treated.

The three ambulances are all of the field type, and are fitted to give first aid and take care of minor surgical dressings without bringing the patient to the hospital. An average of ten minutes running time is all that is necessary to bring any patient to the hospital after the call is received. When the patient arrives at the hospital he may be transferred from the ambulance to the hospital corridor out of sight of passers-by. This may be accomplished because the doors are recessed and the opening is large enough to allow the ambulance to be backed into the entry.

This hospital handled 3,100 cases during the opening month of the exposition, from May 27 to June 25. Forty-five per cent of these were medical cases, and the majority were caused by fatigue or indigestion involving faintness for which a short rest and soothing treatment were sufficient. A number of cases, however, were given x-ray and temporary treatment before the patient was removed to a local hospital.

The personnel to handle these cases consists of four doctors on day duty and two doctors on night duty. Four nurses are on the staff, and this service extends until midnight. Since no cases are kept overnight no nurses are necessary on night duty.

Hospital people who visit A Century of Progress should inspect this hospital because it is unusual in its purpose and appointments, equipment and building structure.

Litigation Sheds New Light on the Hospital's Responsibilities

By CARL P. WRIGHT
Superintendent, General Hospital, Syracuse, N. Y.

This case indicates that when a patient dies the hospital must make a reasonable effort to notify the nearest relative. It is also evident that hospitals should see to it that proper clerical attention is provided the dying patient

NEW problems are constantly arising to vex and irritate the hospital superintendent. Not the least of these difficulties is the ever present ogre of possible and probable litigation against the hospital. Many times this litigation is absolutely without justification but nevertheless it requires an outlay of time and effort to defend.

The General Hospital of Syracuse has just emerged successfully from one of these unfortunate experiences. The litigation was rather unique. It is the first of its kind in the records, so far as we can determine, and for that reason it may be of interest to other hospital executives.

A brief summary of the case follows: A patient from the county home was admitted in October, 1929, through the local free dispensary. The patient, who was suffering from a rare skin disease, gave the admission clerk the usual information regarding himself—name, age, religion, occupation and other data. Asked for the name and address of his nearest relative, he stated that he had a sister living in the city but that he had not seen her for some time. He thought she lived on a certain street but was incapable of giving the house number.

Hospital Sued for $10,000

Thirteen days later the patient died. Before his death he received the last rites of his religious faith. The body was buried at the expense of a local charity in consecrated ground.

Fourteen months later the sister of the deceased appeared at the hospital, claiming that she had just heard of her brother's death and accusing us of various iniquities. She insisted that we should have published the death notice in the local press and broadcast the information over the radio. She also demanded the patient's hospital chart and threatened suit against the institution. Her call was made at night when the record was not available. Recognizing that the woman was under stress, we finally induced her to leave, promising to investigate the matter and to have a report for her the following day.

Investigation showed that our social service department had attempted, immediately after admission of the patient, to find the sister, although the street in question was almost five miles in length. These efforts, made with the help of the telephone book, directory, police and other agencies, were unsuccessful. After the patient's death another attempt was made to find the relative, with similar result.

The sister did not return the following day although we heard from her through one channel or another from time to time. Several months later another demand was made for the record, which was, of course, refused. Our attempt to explain the situation was of no avail and thereafter suit was brought against the hospital for $10,000.

The complaint alleged (1) negligence on the part of the hospital in not locating the sister and notifying her of the death of the patient, (2) negligence on the part of the hospital in not providing the patient with benefit of clergy before death and (3) refusal on the part of the hospital to give information to the sister upon her request.

The plaintiff's testimony was startling. She claimed to have seen a red admission card in our business office on which her name and correct address were recorded. Our information admission cards have always been white. She made other extraordinary statements. Inasmuch as some of her own witnesses testified that the patient had received a Christian burial in consecrated ground, the judge dismissed that part of the complaint.

In its defense the hospital was able to show through its witnesses that every effort had been

made to locate the sister even though the institution was handicapped by lack of definite address. It contended that there was no red card and also denied the several statements which were made by the plaintiff.

Upon the completion of the case our counsel moved for nonsuit and dismissal of the complaint. After considerable argument, the trial judge denied such motions on the ground that there was a common law duty upon a hospital to use reasonable care to ascertain the whereabouts of and to notify the nearest relative or next-of-kin and that whether or not the hospital did so was a question of fact for the jury. He further charged that if the jury found that the defendant had not used such reasonable care under the circumstances, the jury should award such damages to the plaintiff as would recompense her for injuries to her feelings and mental suffering caused by the wrongful act or acts.

After the case had been summed up it was given to the jury and a verdict for the hospital was returned on the first ballot.

This case indicates that while there is no statutory obligation placed on the hospital other than the proper care of the patient, the institution must assume some obligation in matters not connected with medical and surgical care. In this case the so-called common law obligation was clarified only to the extent that the hospital was forced to prove that a reasonable effort had been made to locate the relative. It is also evident that hospitals should, as a matter of safety to themselves, see to it that proper clerical attention is provided the dying patient.

The patient or relative, insofar as the counsel for the New York State Hospital Association can determine, has no proprietary right in the hospital record and the hospital is obliged to produce same only through proper court subpœna.

Regardless of the justification of the litigation, as I have said before, the hospital is forced to expend the time and money necessary for defense. At the present moment when the expenditure of every dollar merits serious consideration, it is deplorable to have to waste even a penny in defense against this class of litigation.

It seems pertinent that the members of the public, who, in the last analysis own and operate the hospitals and pay the bill, should see to it that a reasonable interpretation of the hospital's obligation is made by statute and that some reasonable protection against promiscuous litigation, such as the above, is afforded by the same procedure.

How General Hospitals Can Enlarge Service to Chronics

A study on the subject of "Chronic Disease in New Jersey" was recently completed by the New Jersey Department of Institutions and Agencies. The survey, which was made at the request of the state legislature and the governor, developed some interesting data.

General hospitals, recognizing the problems of the chronically ill, realize their services may be enlarged in the following way, the report states:

1. Establishment of special wards in the hospital, preferably detached or semidetached, easily accessible from the street and avoiding the necessity of entering the hospital proper. These would be under the same general management, use the same kitchens, laboratory and other hospital facilities. The costs of operation and hence the weekly charges for service would be considerably lower than in the hospital proper because of a smaller nursing and attendant staff. Patients might be admitted to those wards directly from the community or transferred from the hospital proper when convalescing from an acute illness.

2. Affiliation with a convalescent home or nursing home or some institution prepared to give intelligent supervised attendant care and to follow up cases after acute symptoms have subsided. Since operating costs of these institutions would be less, the hospital could transfer recuperating patients promptly. Lack of suitable accommodations to which patients might be transferred has kept many hospitals from accepting chronic cases.

3. Extension of dispensary and special clinic services for chronic diseases. These would be staffed not only by competent physicians and clinic nurses but by a sufficient number of nurses with special social service training who could carry over into the homes and to the relatives of the patients prescribed methods of care, and who would stress the importance of continued clinic attendance.

Safeguarding Against Excessive Heating Plant Repairs

The annual cost of heating system operation is a sizeable proportion of the total annual expense for operating the building it serves. While the actual fuel cost is the major part of the annual heating system expense, heat system maintenance may be excessive if precautions are not exercised to keep service and repair bills within reasonable bounds. This is of particular importance where automatic fuel burning equipment is installed. If the following precautions are observed, says *Domestic Engineering*, the heating system will yield greater satisfaction:

To reduce maintenance, the heating system should be given careful attention several times throughout the heating season. Particular attention should be given the following items: (1) preparing the boiler for the summer shutdown; (2) placing the boiler in operation in the fall; (3) checking the controls of automatic fuel burning equipment at least once a year, preferably when the equipment is placed in service in the fall, and (4) attending to the boiler during the heating season to ensure that flues are free from an excess accumulation of soot and ash.

Once a London Warehouse—Now a Psychiatric Clinic

An outstanding example of what may be done in the rehabilitation of an old building to meet the needs of modern psychiatry is revealed in the experience of the Institute of Medical Psychology of London, England. With a warehouse as a start, a modern psychiatric clinic has been established, costing between $25,000 and $30,000

By RAYMOND P. SLOAN
Associate Editor, The MODERN HOSPITAL

IT HAS taken no greater expenditure than £7,500, that is in the neighborhood of $25,000 to $30,000, to transform a warehouse in London into a modern psychiatric hospital—the Institute of Medical Psychology. In addition to the importance of this development in supplying increased facilities for the alleviation of suffering among those handicapped by minor maladjustments, it represents an outstanding achievement in modernization.

For many years Tavistock Clinic, London, has been recognized as carrying on a noteworthy work. The clinic was started by a group of medical officers who recognized the inadequacy of stereotyped medical treatment for shell shock and personality problems. Their efforts soon became manifest in pioneering the cause of mental hygiene throughout England.

The original quarters in Tavistock Square, however, became inadequate and it was necessary to look elsewhere for accommodations. At that time, too, it was decided to change the name from Tavistock Clinic to the Institute of Medical Psychology. Quarters were found finally in Gower Mews, ideal in many respects but principally because the building is directly across the street from the site on which the future University of London is to be erected and is also adjacent to the London School of Hygiene and Tropical Medicine. The move, too, was held propitious by University College in view of the university having adopted the principle of recognizing out-patient clinics for teaching directed toward the degree of M.D. in psychology. The only difficulty was that the building had been used as a warehouse. Here was a task that obviously would engage all the ingenuity of architects and decorators.

How well the work has been performed is evidenced by the accompanying illustrations. While from the outside the building still possesses some suggestion of the strictly commercial purpose for which it was designed, its interior is a revelation of what can be accomplished in rehabilitation at comparatively small expense.

Extremely comfortable, the clinic radiates a pleasant atmosphere that has an immediate effect on the patient. Its general treatment is distinctly modern. The waiting room is noteworthy because of its cheerful tone. In fact, the idea was to have

One of the seventeen consulting rooms. Soft shades of green are the predominating tones in these rooms.

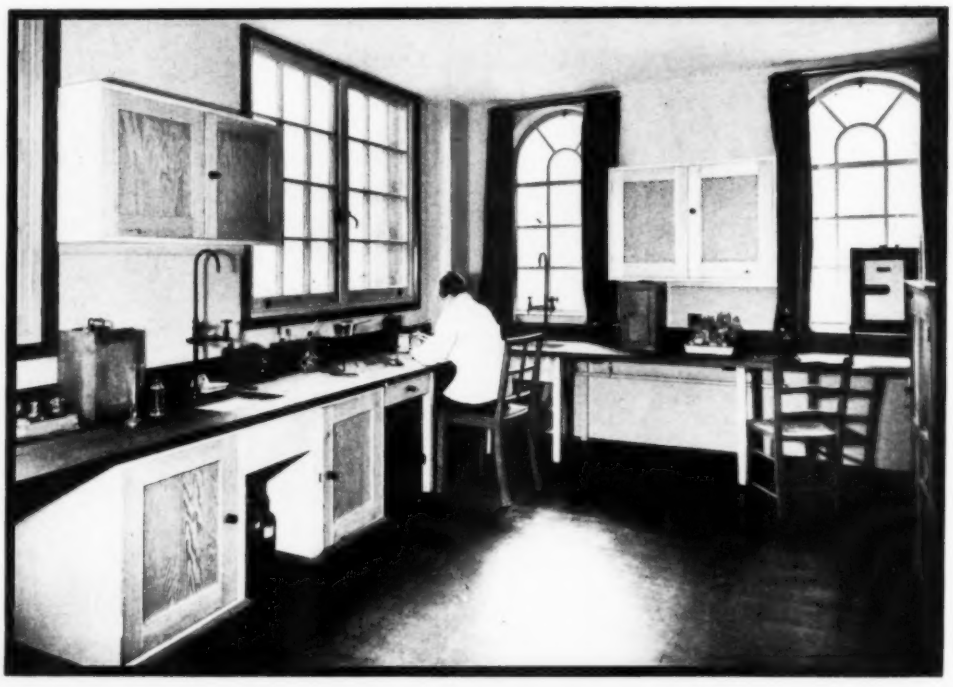
The modern note as revealed in the decorative treatment of the adult patients' waiting room is characteristic of the furnishings and decorations throughout the entire building.

each patient feel the effect of the institution at once before even passing on to the seventeen consulting rooms.

Every patient who enters is first given a thorough general examination by a diagnostic physician who possesses a good understanding of psychiatry. A senior physician then decides which staff member shall treat the patient.

The consulting rooms are far removed from the bareness of the oldtime out-patient department. Attractive hangings are draped at the windows. A soft rug of modernistic design relieves the coldness of an uncovered floor and three chairs, two of them exceedingly comfortable, a desk and a couch, comprise the rest of the furnishings. Every detail has been carried out in excellent taste and with harmonious effect. Green is the dominant color.

Other features of the equipment are well worth studying. There is, for example, a charming room designed solely for remedial play for children where the youngsters are closely watched without being aware of it. This is also placed at the disposal of children who may be waiting for interviews. The worker in charge records her observations of various aspects of each child's behavior, and brings the facts to the attention of the doctor



This view of the institute's modern pathological laboratory, containing complete equipment and facilities, illustrates how the interior of the old warehouse has been changed.

The new home of the Institute of Medical Psychology, London, England, which is a remodeled warehouse. The work was accomplished efficiently at a surprisingly low cost.

who happens to be treating the case. Modern laboratory facilities are provided, as well as a photographic department designed for anthropologic research, separate waiting rooms for adults and children, restaurant facilities for patients and staff and a large lecture hall which is also used for handicraft. Particular mention should be made of the library which is housed in an exceedingly attractive room, with plenty of light and with bookshelves and tables for reading and reference work.

Double Amount of Work Can Be Done

The work the clinic carried on in its old quarters gives an indication of what may be expected from the new facilities. Approximately 11,000 hours of treatment were provided annually for 1,250 patients, with a waiting list so long that a new patient, unless an emergency case, could not be admitted for six months. The clinic likewise has been carrying on the graduate training of a group of medical men from all parts of the world who serve as junior members of the staff. It provides special courses for general practitioners, lectures for social workers and for members of the general public anxious to learn more regarding the mental health of adults and children.

A special children's clinic and a certain amount of scientific investigation are other features of the work carried on. In its new building, the institute looks forward to doubling the quantity of its work, and at the same time improving its quality.

Although the new quarters are a great improvement over the old, the institute is anticipating the time when it may have a plant built especially for teaching and research purposes as well as for therapeutic work. This it hopes will include greater facilities for in-patient care. Now, patients coming from without the city or those who need to be removed from home environment are cared for in a separate building known as the "hostel." Despite the limited facilities, this in-patient department has done remarkable work. Prescribed courses in arts and crafts are carried on and several of the rooms have been completely redecorated by the patients who as a result have become a cheerful and useful group. The average stay of a patient is about two and a half months.

The present step, therefore, important as it is, is particularly significant in depicting a trend that will one day find London University the center of a coordinated development in the field of medicine beyond anything in England today. It is significant, too, in the opportunity it affords for studying hospital modernization and rehabilitation as it is being practiced not only in England but also the world over.

Blood Tests Cost This Laboratory Only Seventeen Cents Each

By HELEN VAN SANT
University of Chicago Clinics

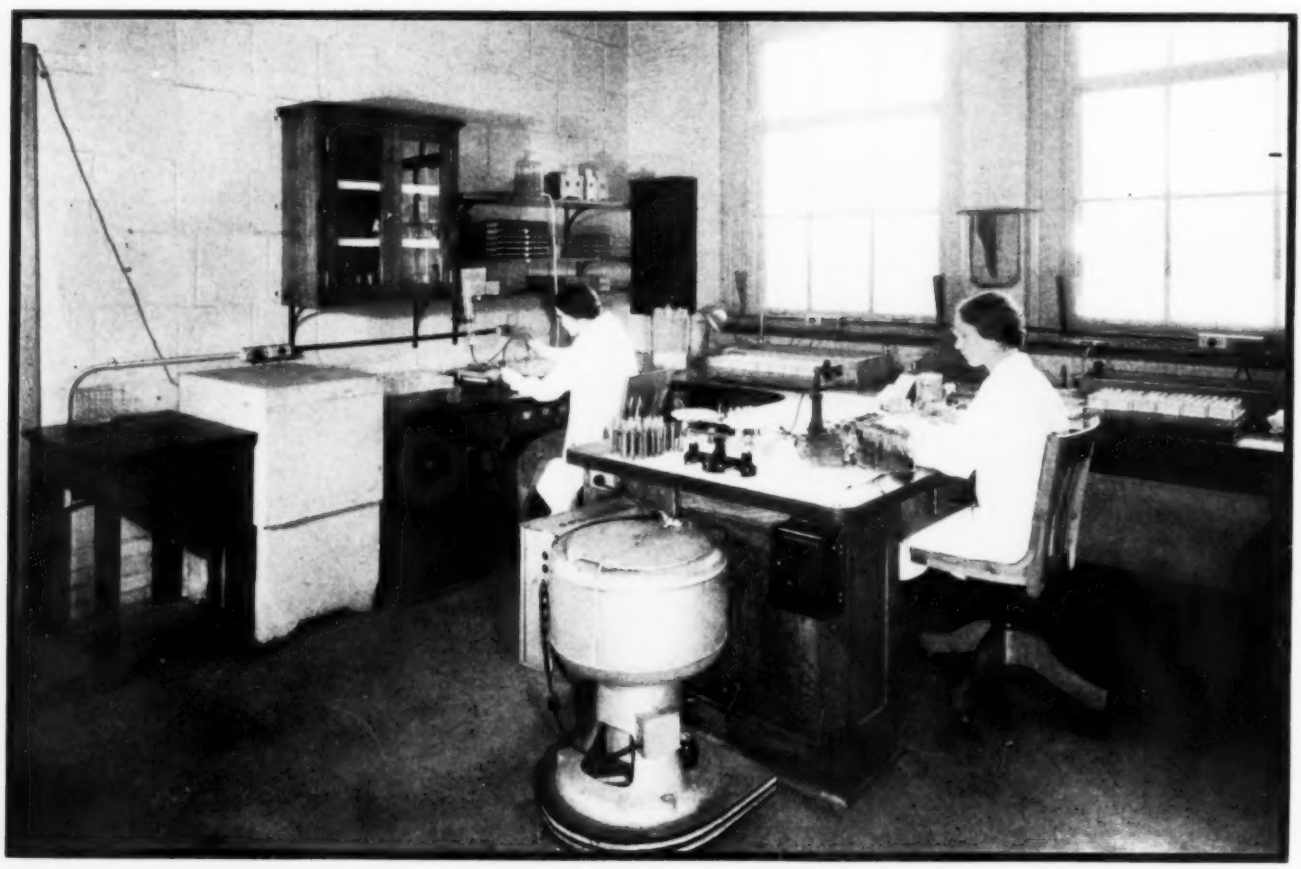
THROUGH careful planning of physical details the special Wassermann laboratory of the University of Chicago Clinics conserves the time of its technicians and enables them to produce a large volume of work at low cost.

As is shown in the picture the serology laboratory is not a large room (15½ by 17 feet), but it is so arranged in two complete working units that two trained technicians can handle a daily run of from 100 to 150 Wassermann and Kahn tests.

These U-shaped working units are divided by a common double desk at the head of which is placed a sunken 56° water bath and at the foot a centrifuge balance and necessary accessories for centrifuging specimens. Swivel chairs are placed at opposite sides of this desk, allowing the technicians to turn about and reach without loss of motion or time practically everything necessary for their work.

Conveniently placed for each worker are 37° water baths—also sunken to allow easy manipulation—electrical pipetting machines for pipetting complement, sheep cells, etc., and cupboards for racks and tubes. In the turn of each U are racks for pipette cans. Thus everything is within easy reach.

On one side of the room, as shown in the picture, is a receiving table for specimens and the Kahn shaking machine. On the opposite side, not shown, is an electric refrigerator. There is a movable



The serology laboratory, while not a large room, is so arranged in two complete working units that two trained technicians can handle a daily run of from 100 to 150 Wassermann and Kahn tests.

table which is placed over the centrifuge when the centrifuge is not in use, providing space for soiled glassware. Trucks are brought in by boys from the glass washing room for removing the tubes and the other glassware after the tests have been finished.

The electric pipetting machines save an enormous amount of time. They are made on the principle of Woodyatt's pump and were supplied by Hipple at the University of Wisconsin.

There are many other time saving devices, such as centrifuge tube holders carrying three tubes each, which make it possible for twenty-four specimens to be centrifuged at one time. The pipettes recommended by Kolmer designed specially for his test are of course used.

The Kahn shaking machine is essential for this amount of work, as shaking by hand would be too slow and too costly.

Thus the general arrangement of the room is such that the work is carried on with a minimum amount of exertion and confusion.

As for the methods employed, the Kahn precipitation test and the Kolmer quantitative Wassermann test are done on every blood received, and Ross-Jones globulin and Wassermanns are made on all spinal fluids. At first, the complete quantitative Kolmer-Wassermann was done; that is, five tubes and a control. Since, however, much of the work is routine and the results therefore negative, only the first two tubes and control are now done, the six-tube test being made only in special cases when requested. This eliminates a great deal of unnecessary work.

Sheep cells for the Wassermann are procured once a week. If they are washed two or three times in gelatin Locke's and then stored in the ice box with Locke's saccharose solution they keep very well for one week. This method is recommended by Kolmer.

In this laboratory, all of the Wassermann work for every unit of the University of Chicago Clinics is done. This includes a considerable amount of laboratory work for the Chicago Lying-in Hospital and dispensaries.

This laboratory turns out about 430 blood analyses a week at an everage cost of seventeen cents each. The detailed weekly cost in the laboratory is as follows:

Glass washing and animal care	$15.00
Laundry	.50
Stores	8.92
Animals purchased	3.55
Salaries, 1 full-time technician[1]	31.00
Salaries, portion for supervisor	15.00
Blood	.50
Total	$74.47

[1]Apprentice technicians are being substituted temporarily for one of the trained technicians.

New Book for Workers in Mental Institutions

By WILLIAM A. BRYAN, M.D.
Superintendent, Worcester State Hospital,
Worcester, Mass.

"Hydrotherapy in Hospitals for Mental Diseases," by Dr. Rebekah Wright, hydrotherapeutist, Massachusetts department of mental diseases, is designed, according to the author, to present in concise detail the technique of the hydriatic procedures that have proved practicable in hospitals for mental diseases, to instruct hydrotherapists in accurate recording and in the management of the hydrotherapeutic department, to outline for psychiatrists the hydrotherapeutic indications in conditions which accompany the various psychoses, to emphasize the importance of precise prescriptions and accurate records and to offer suggestions for the construction and equipment of hydriatric suites. The book fulfills this purpose admirably.

The book is divided into four parts. Part 1 is for nurses, instructors and hydrotherapists, and covers the importance and scope of hydrotherapy in hospitals for mental diseases, anatomy and physiology of the skin, physiologic effects of cold and heat, local and general applications of heat and cold, revulsion, neutral applications, friction and irrigations. Among the forty-five to fifty procedures that are recommended, the technique and effects of the wet sheet pack, compresses, electric light and vapor baths, the sitz bath, the continuous bath, the salt glow, seven forms of the douche, gastric lavage and colonic irrigation are discussed in detail. The section is illustrated with fifty-five pictures of procedures, three of fabrics and utensils, three anatomical drawings and three radiographs.

Part 2 is for hydrotherapists. The technician is advised in regard to costumes, water supply, demonstrations, daily preparation for tonic baths, the occupation and entertainment of patients, and the handling of emergencies. Chapters on housekeeping and records and reports are of particular value to the hydrotherapist.

Part 3 is intended primarily for physicians, and in the short space of fifty-two pages Doctor Wright has condensed the essential hydrotherapy information with which all physicians dealing with mental diseases should be completely familiar. Hydrotherapy for conditions occurring in the various psychoses is outlined in detail, particularly as to temperature, duration and frequency of the treatments.

Part 4 is intended for superintendents, and deals with the subject of construction and equipment for hydriatric suites. The suggestions are based upon the author's twenty-five years' experience in cooperating with architects and superintendents in the planning of tonic bath and sedation suites. There are twenty-eight cuts and drawings of fixtures, three plans of recently constructed hydrotherapeutic departments and three model plans which can be used for such departments.

Well Kept Records Reveal Errors and Obviate Their Recurrence*

By JOSEPH C. DOANE, M.D.
Medical Director, Jewish Hospital, Philadelphia

IN THE July issue of The MODERN HOSPITAL the importance of a proper institutional filing system was stressed. That no system can serve its full purpose unless diagnoses are accurate and complete was also emphasized.

The opinion was expressed that it would be far better to allow the dust of years to obliterate hospital records unless correct conclusions had been drawn in a large majority of instances as to the nature of the illnesses for which patients had been treated. Perhaps this statement should be qualified by the further comment that errors are often useful if they serve to prevent the recurrence of similar mistakes. The physician learns by courageously facing the fact that mistakes have occurred. It is necessary, however, to be aware of such errors before preventive measures can be taken to obviate their recurrence.

The Chief Aim of a Filing System

A proper filing system for hospital records has as its chief aim the recording in an orderly fashion of diagnoses and the results of treatment so that reference can be easily made to such statistics at some future time. But merely to locate promptly the individual clinical record of a past patient is not enough. The classification of morbidity and mortality statistics must be so refined that experience information in the treatment of definite types of disease—complications, frequency of incidence and even in some cases the outstanding symptomatology—must be easily available. It is the purpose of this article to discuss in detail some angles of the general methods concerned in arriving at correct diagnostic conclusions and particularly methods of using such data for clinical-pathological comparison when patients come later to necropsy or are subjected to surgical treatment.

The adequacy of methods adopted for recording admissions, transfers, discharges and deaths bears directly on this subject. When a patient is admitted to the hospital, there begins a series of records which is only concluded by his discharge from the institution or by his death. Admission card systems of institutions vary greatly.

In many instances the receiving clerk, after admission has been decided upon, records on triplicate cards, usually 3 by 5 inches in size, the necessary data relative to the identification of the patient, from both personal and professional angles. One of these cards is sent to the information desk so as to place the patient immediately within the institution; another is sent to the record room, and the third frequently accompanies the patient to the ward. The information desk must, of course, be kept continually informed as to the location of patients within the hospital. This makes possible the maintenance of a condition sheet from which the information clerk may quickly supply information in answer to telephone requests regarding the condition of patients. Sometimes this clerk must also prepare a check list covering the daily census.

The card that accompanies the patient follows him wherever he goes and contains the proper inscriptions including his original assignment and the length of his stay in each department in which he is treated. Such information as name, address, age and often provisional diagnosis of the patient is also found on this card. Sufficient space is provided for a chronologic record of transfers, reassignments and the date of discharge or death.

Sometimes Only One Card Is Used

In other institutions only one card is executed upon the admission of the patient. This card is sent with the patient to the ward and is kept there in an alphabetic index. As in the first system, the card accompanies the patient wherever he goes. Upon discharge or transfer, the patient's card is attached to the chart and dispatched to the first place of record so that the index files in the information office may be kept up to date. This card also contains the initialed approval of the physician treating the patient, as well as the approval of the hospital administrator, the latter officially completing the transfer or discharge. When the patient leaves the hospital this card

*Practical Administrative Problems series.

frequently serves in the record room as a finding index covering future admissions or as a source of information concerning past treatment. In still other institutions the front sheet of the clinical record serves the purposes that have been described for the card system.

When births take place in the institution the procedure is usually the same as for a regular admission. Sometimes, however, hospitals consider the newborn infant as an admission only when it remains in the hospital longer than two weeks. When this is the case, the baby receives the same admission number as the mother. If the mother departs without her baby, a separate number is usually assigned. There seems to be no good reason why an infant born in the hospital should not always be considered as a new admission and assigned at once an admission number.

A Troublesome Problem

At the end of every day's institutional business a triplicate list is forwarded to the administrator's desk from the receiving ward. This shows the admissions and discharges for the day and serves as a check against the card system already described. Such a list permits a careful daily audit of the census of each department. When the triplicate card system is not employed, the record room clerk first learns of the admission of the patient when she receives the daily admission slip. She then proceeds to fill out a card for each new patient and this she places in the "new patient" file.

A difficulty arises at this point that is frequently troublesome. Inquiry is often made, particularly in teaching institutions, as to the presence in the hospital of a patient exhibiting, for example, the clinical picture of mitral stenosis, an acute parenchymatous nephritis or a typical lobar pneumonia. Rarely can such information be supplied by the record room and perhaps it is unreasonable to expect that this be done. More often diagnostic lists are found in the ward office, although the diagnoses there set down rarely represent more than mere preliminary impressions. It is sufficiently difficult, as a matter of fact, to secure thoughtful and accurate diagnoses even after the patient has been under treatment for a considerable length of time.

It is perhaps unwise to keep diagnoses of private patients on file in a place where nurses and visiting physicians generally may inspect them. It is perhaps best in the private departments for condition sheets containing diagnoses to be kept away from the public gaze since it is conceivable that a knowledge of the patient's real condition might embarrass both himself and his family.

Physicians telephoning the hospital for the admission of a patient are sometimes requested to supply a diagnosis. This practice may not always be necessary, although it must be conceded that undesirable patients may enter the hospital unless this is done. Even this precaution is of little value if the physician desires to be evasive. When harmful evasiveness or deliberate misstatement is practiced by an individual physician, the proper corrective steps should be taken in each instance.

One of the many harassing difficulties confronting the record room clerk is to secure prompt completion of clinical charts following the discharge of patients. If the cause for this difficulty were always a common one, some solution could probably be found. Since absence from the city, change of service, illness and other unavoidable causes result in delay on the part of the physician in visaing clinical charts the remedy is not simple. Nevertheless, the physician is often guilty of inexcusable procrastination in this matter. Some hospitals are content when they are able to secure, more or less promptly, a correct chief diagnosis and are reluctant to insist that complications, sequelae and coincident infections be fully described on the diagnosis sheet. Another difficult end to achieve is the prompt recording of the description of operations in the surgical division. A careful visa of all histories must of course be made before filing. When ward services change the visiting physician should not permit unfinished records to remain behind him but this too often happens. Sometimes the chief himself is unwittingly at fault when he discharges a patient without notifying the intern, thus making difficult the prompt completion of records and the writing of final diagnostic and prognostic statements.

How Some Hospitals Assist the Record Clerk

The record room clerk must have the courage of her convictions. She must be quick to detect errors. She must never be tempted to seek the easiest way by burying incomplete and inaccurate charts in the files without making an effort to correct the omissions and mistakes.

Some hospitals assist the record room clerk by establishing definite rules for the making of diagnoses. For example, it is often required that every chart must have a provisional diagnosis signed by the chief physician within thirty-six hours after the patient's admission. Again, every patient should have a completed clinical record with preoperative diagnoses carefully set down before surgical treatment is instituted. Before necropsy the same definitive action should be taken. Such information may be inscribed on the proper clinical sheet or a separate clinical-necropsy sheet may be employed to set forth carefully the clinician's

diagnosis before the body is incised. In some hospitals where this action is not taken the percentage of correct ante mortem diagnoses as published is astonishingly high because the pathologist's diagnosis is substituted for that of the clinician on the final record sheet.

The diagnosis, therefore, should be made by the clinician with the same attention to detail as is the anatomical diagnosis which is dictated by the pathologist following necropsy. For example, the chart of a patient with a clinical diagnosis of myocardial disease should certainly contain the statement that this condition was accompanied by generalized edema with ascites and hydrothorax—if such was the case—and that there were other accompanying conditions such as congestion of the spleen, liver and kidneys. Unless this is done, the pathologist will have every right to assume that the clinician overlooked the presence of such complicating conditions or that he ascribed little importance to them.

The same attention to detail should be expected of the physician who, after study in the medical division, transfers the patient to the surgical department for operation. Diagnoses here are rightfully reversed. For example, a patient who is admitted to the medical department with a diagnosis of pneumonia develops an empyema. The transfer card should state that empyema is the principal diagnosis determining admission to the surgical ward. Lobar pneumonia is now the disease of secondary importance. The preoperative diagnosis should be made by the medical division and if the surgical staff does not concur therein, dissenting statements by this group of physicians may be made in the proper place on the clinical chart. When staff members disagree as to the cause of illness, it is proper for several diagnoses to appear on the clinical chart together with the signatures of the physicians supporting each.

Probabilities Expressed in Percentages

The diagnosis is often uncertain and several opinions may be expressed in order of their probability. For example, a patient suffering with pain in the right upper abdomen is transferred to the surgical ward for operation. Some hospitals would require that this patient's chart contain an expression of the various possibilities in order of staff belief. Such a patient might present a diagnosis as follows: acute cholecystitis, 3; duodenal ulcer, 2; pancreatitis, 1. Such a statement of probabilities may be expressed in percentages. It should be inferred by the surgical group that the clinician referring the case believed acute cholecystitis to be three times as likely as duodenal ulcer.

If several conditions are thought to be present coincidentally, the same system may be employed. For example, a patient with disease of the heart, blood vessels and kidneys might be diagnosed as follows: acute glomerular nephritis, 90; arteriosclerosis, 90; aneurysm of the aorta, 50; cirrhosis of the liver, 20. Here the pathologist is able to infer that the probabilities of the case have been thoroughly considered and that it was believed that several conditions would be discovered at necropsy, the probability of their occurrence being expressed in percentage form.

Coincident Conditions Are Important

Usually the physician responsible for completing the chart is content to set down only the main diagnosis. Pathologists inform us that active and passive congestions, edema, enteritis, endocrine dysfunction, lymphadenitis, bronchitis, skin diseases and congenital abnormalities are the conditions which, though plainly evident on the necropsy table, are too frequently omitted from final clinical diagnoses.

It is of course important for the medical world to appreciate the existence of more or less usual disease accompaniments of various classical conditions. It is of the greatest interest to physicians generally to know the possible sequelae of these diseases. Complications are secondary conditions that arise in the course of the chiefly disabling disease and sequelae are conditions that follow or complicate late convalescence. Coincident conditions may be of the same grave portent to the patient as the disease for which he was hospitalized. At the same time, several pathologic conditions, insofar as human discernments are concerned, may be of equal danger to the patient's life. It is, therefore, not always possible to state that the patient is placed in greater danger from a disease of the heart than he is from a coincident disease of the kidney or that he is more likely to die of a tuberculosis of the lung than from a similar infection of the kidney. Yet it is frequently possible to estimate the comparative importance to the patient's welfare of such concurrent states.

Possibilities for expression of opinion in the diagnosis as to the etiology, anatomic location and functional effect of disease are often overlooked. For example, the mere diagnosis of an arthritis tells little. Frequently such a statement appears on the chart without even an estimate as to the acuteness or chronicity of the condition. When such a diagnosis is qualified by the statement that a gonorrheal arthritis of the left knee exists, much clinical value is added to the information appearing on the record. If a diagnosis of syphilitic aortic insufficiency with passive congestion of the

liver and ascites is employed, not only is the nature and location of disease thus denoted but the functional effect of its existence is also indicated.

Any filing system that does not make possible the proper recording of such etiologic, anatomic and functional diagnoses is defective. Diagnoses are often so broad that they may be said to be "inaccurately correct." For example, a diagnosis of syphilis may imply only that such an infection in one of several stages exists, while no clarifying statements are given as to the main organ involved. Enough emphasis has been placed on the necessity of completeness and accuracy in diagnoses. Although the presence of a serious condition may be thus indicated, no attempt is made to describe accurately the etiologic reason for its existence. Bronchopneumonia is a serious disease but it is rarely, if ever, primary. Moreover, bronchopneumonia is frequently fatal because it complicates some other serious condition and acts as a terminal state. Measles and many other acute contagious diseases, as well as nephritis and heart disease, are often complicated by a lobular pneumonia and the original cause of death is often just as much the primary condition as the secondary one.

If a complete and simplified filing system is adopted, whether filing is done alphabetically, numerically or by anatomic classes such as disease of the arteries, the gastro-intestinal system, the pulmonary system, the nervous system, the genito-urinary system, the test of such a system is its flexibilitiy, its ease of reference and the provision for filing and storage of future charts. When such a system is employed and when the hospital personnel are well trained, it should be possible at any time to ascertain the most frequent diagnostic errors made by the staff. Having arrived at this point, it is possible to avoid these errors.

Infections of the pericardium, the presence of a terminal bronchopneumonia and the site of dissemination of a cancer appear to be the most difficult conditions to discover. While this may not be true in all institutions, it certainly is true in many. Regardless of whether or not such a generality can and should be made, the lesson to be learned from this statement is that the general hospital staff, having discovered that these conditions were most frequently overlooked in a previous year, will in the future endeavor to diminish the percentage of error in these conditions.

Justification for the expenditure of great sums of money and long hours of effort in filing records must lie only in the benefit to be derived from this activity by present and future patients. If such records do not benefit present and future patients, because hospital administrative and professional staffs have been careless in preparing and filing them, then the end results will be no greater than those that come from successful solving of a jig-saw puzzle.

In these articles dealing with the hospital record filing system the following points have been emphasized:

1. No filing system can be efficient and useful unless diagnoses are accurate in a large percentage of cases.

2. Every hospital should require of its staff assistance in developing a system characterized by simplicity, economy and scientific accuracy.

3. To neglect the proper compilation of clinical charts is to fail in an institutional duty to the patient and to the public.

4. The record room clerk is, in importance, one of the key officers of the hospital and must possess unusual qualities to carry out her work properly.

5. The board of trustees should inquire into the type and promptness of the diagnostic work performed in the institution under its charge.

Who Should Treat the Hospital's Accident Cases?

The problem frequently arises in the hospital as to the physician to whom patients of the private room class should be assigned when they are brought into the accident ward. Usually members of the surgical staff are allotted regular receiving days. For example, to Surgeon A are assigned all ward and private cases entering the hospital from Wednesday noon to Saturday night and to Surgeon B all patients admitted during the remaining portion of the week. But a complication arises when an accident patient is brought to the hospital and the family physician desires to treat the patient after the patient has been placed in a private room.

The solution to this problem lies in the presence of thorough service rules. Every member of the staff should be classified as to the privileges he is allowed. For example, the fact that a physician is satisfactorily filling the position of pediatrician to a hospital does not guarantee that he is capable of treating an accident case from his own practice. Indeed, he often should be prevented from doing so. When the hospital accepts an accident case it guarantees proper treatment even though the patient himself, not fully understanding the incapabilities of his own family doctor, desires that the latter should treat him. Of course, should the family physician possess surgical privileges at the hospital no difficulty arises. Even though in some cases the hospital loses a private room occupant by insisting that skilled surgical treatment be given, the adoption of such a policy is wise. The public has yet to learn that all physicians are not equally qualified to practice medicine, surgery and other specialties.

Editorials

Looking Forward

THE long awaited corner in business activity seems definitely to have been turned. Since the low point in the middle of March, the indexes of business activity have gone steadily upward. A slight flattening of the curve the latter half of June was followed by a rapid rise in July. These indexes, which are based on such factors as steel mill operations, building contracts, coal production, electric power output, carloadings and currency in circulation, are probably reliable indicators of business conditions. While no one would hazard the statement that "prosperity is just around the corner," many now believe that we have started on the long, slow upgrade to a more normal economic life. We can begin to think of the depression in the past tense. While the recovery program may fail, most of the present available evidence points the other way.

The voluntary hospitals of America have come through the depression with flying colors. While the colors may have had a few holes shot in them, and the color bearer may now and then have staggered under his load, the flag has remained at the top of the staff and it has gone steadily onward. The hospital slogan in effect has been "A financial deficit if necessary but never a service deficit." As a consequence hospitals are in a position to benefit from enhanced public good will as soon as the public again has funds.

If hospitals are to benefit as they should from the turn in economic affairs they must consciously plan for a new cycle of hospital service. They must begin to think about the effect of new conditions and how to adapt their service to new needs.

At the top of the list, perhaps, will come the fiscal problems: paying up deficits that have accumulated during the last three years, preparing to meet advancing prices and laying in stocks where possible, and considering the advance of charges for hospital services, if necessary. It would seem wise to delay advances in hcspital charges as long as possible in the expectation that increased paying occupancy at present prices would compensate, at least temporarily, for higher costs. Certainly there are among the people many with physical ailments of a more or less chronic nature that have been long neglected. Too rapid an advance in hospital charges would act as a barrier to proper care for these persons. But the problem must be faced.

The hospital plant has suffered considerably during the last quadrennium. Much equipment needs modernization, old buildings should be renovated and rehabilitated, and attention should be given to rearrangements of floor space. Probably there will be no rapid return to the heights of prosperity experienced in 1926 to 1929. Therefore, the demand for de luxe private rooms and private suites will revive slowly. As the pressure on the ward service falls, the demand for moderate priced semiprivate and less expensive private rooms will increase. These trends should be considered in plans for physical rehabilitation.

Some hospitals will not be content merely with renovating old buildings. They needed new buildings in 1929 and they need them still more today. Their task is to take full advantage of the wide public interest in hospitals and give direction to that interest. After every national business slump there has been a period of lag in hospital support. Skillful leadership can shorten the lag period. Private philanthropy generally does not initiate—it responds to persuasion and interpretation. Appeals for funds in 1933 and 1934 will have to be on a more democratic basis than the appeals of the Coolidge era. Huge fortunes are not encouraged by Roosevelt policies—the aim is to spread the nation's funds among a larger group. This is a factor in planning appeals.

The American Hospital Association Convenes

THE month in which members of the American Hospital Association gather at their convention city should be marked in red letters on the institutional calendar. During a year of more or less troublesome times policies become confused, procedures of doubtful value are practiced and organization methods become inefficient.

The hospital executive will not find the solution for these difficulties by remaining at his desk. Boards of trustees should look with suspicion upon the stay-at-home administrator. Perhaps he is afraid to leave his work long enough to attend conventions lest another replace him. Or perhaps he does not feel the need of mental refreshment.

The 1933 convocation must meet squarely problems of great moment. The hospital has been accused of aspiring to become the selfish center of community medical practice. It has been pictured as the competitor of the doctor. It has been challenged to offer a solution to the vexing problems of medical and social community economics. Hospital executives can no longer meet such charges

with dignified silence. The institutional world must disprove any accusation that its intentions are harmful and present constructive suggestions that will be acceptable to both physician and patient.

The American Hospital Association must assume a leadership too long delayed. Its public relations committee deserves credit for the splendid steps it has taken during the past twelve months toward assuming this leadership. The program of the coming convention will be replete with helpful information. It is not a question this year of whether or not the executive can afford to go. It will be extravagant to stay away.

An Opportunity

ONE of the outstanding developments in the postwar period of the American hospital was the American Conference on Hospital Service, which many students of medical administrative history will gratefully recall. Starting with a comprehensive program of community service as a foundation, the conference enlisted the interest of the most representative medical and allied associations which flourished at that time, such as the American Hospital Association, the American Medical Association, the Association of American Medical Colleges and the American Nurses' Association. The American College of Surgeons, having elaborated hospital standardization plans of its own, proceeded to work on an independent basis. That was in the decade preceding the fateful year 1929, when there was considerable social readjustment to be made in response to the world catastrophe.

Now, following the convulsive social and economic changes of the last four years, we have a revival of the spirit of the American conference. Under the auspices of the American Hospital Association, and with the stimulus supplied by its committee on plan and scope of last year, the Council on Community Relations and Administrative Practice has come into being, with its program of hospital standardization, group hospitalization and smaller councils that are recommended for local organization throughout the country. With the need for a reorganization of the social scheme of things, made obligatory by the revolutionary changes in the financial world (on which hospitals are so dependent), the council is planning in a manner that justifies the optimism of its well-wishers.

There is so much confusion and uncertainty in the world of social service these days that any intelligent plan promising to bring clarity and order out of the chaos that seems to surround and affect us, should be welcome. All of the resources of the American Hospital Association are squarely behind this new project but, however thorough and efficient the work of national organizations like the American College of Surgeons may be, it will be for the common good if a productive form of cooperation can be achieved.

The chief point of contact is, of course, administrative practice in hospitals, to the efficiency and advancement of which both the Amerian Hospital Association and the American College of Surgeons are committed. A typical instance of an opportunity for joint action may be found in the need for establishing and enforcing administrative standards for hospitals which devote their facilities either entirely or in part to the care of maternity cases. Other and equally important opportunities are available during these trying times when the rank and file is groping blindly for social guidance into the clear daylight which economists and statesmen tell us will shortly come.

As the plans of the council develop there will doubtless be additional need for local, as well as national, organizations to join forces. The opportunity is here and a well balanced organization to make full use of it is highly desirable. It is the feeling of every thoughtful worker in the hospital field that the program of the Council on Community Relations and Administrative Practice of the American Hospital Association[1] will come to fulfillment and help to lead us out of the darkness into which the economic revolution has thrust our social institutions.

To Charge or Not to Charge

FRANTIC endeavors on the part of administrators to increase hospital income have resulted in practices that would be ludicrous if they did not so directly affect the welfare of the patient and the community.

Clutching at economic straws has almost wrecked some institutions. The placing of many minor services and supplies on a fee basis has produced an unfavorable and suspicious attitude on the part of the public. Charges for radios already installed in rooms, dressings, salt solutions, minor medicaments and even ice water are so picayune that it is small wonder hospital patrons rebel when they receive their bills.

These paltry sums are dearly gained. The confidence of the public is priceless. A few dollars collected for cathartic pills or for salt solution for

[1] For a general description of the progam see "The American Hospital Association and Its Future Program," by S. S. Goldwater, M.D., The MODERN HOSPITAL, October, 1932.

intravenous use will be lost many times over through lack of patronage and suspicion of the hospital's methods. An institution that finds such shoddy practices necessary should close its doors rather than harm the good name of hospitals everywhere.

Nurses and the Blanket Code

THE voluntary blanket agreements which the President in July asked the nation's employers to sign specifically exempt "registered pharmacists or other professional persons employed in their profession," from the provision of the minimum wage and maximum hour agreements. This clause, as reported in last month's issue, has been interpreted by General Johnson to include nurses, interns and laboratory workers. Executives earning over $35 a week are also exempt from the maximum hours. So about one-half of the average hospital's employees are not covered by the provisions of the agreement.

But if hospitals are not forced through pressure from the President to adopt shorter hours and higher wages for nurses, does that end the matter? Admittedly there are few if any occupations where unemployment and distress have been greater. The psychology of the present time is that unemployment is not a visitation from an angry God but rather a man-made terror which man has the responsibility of conquering. If one accepts the older economic doctrines, all of the recent attempts to remedy unemployment by shorter hours and higher wages must be classed with lifting oneself by one's bootstraps. A newer group of economists, however, challenges the whole structure of traditional economic thinking. They assert that our economic machine has come to the verge of wreckage because it failed to distribute widely enough the benefits of modern industrial organization and because it was too dependent upon financial profits, present or prospective, for motive power. The correctness or error of these newer economic theories is now to be put to a laboratory test on a stupendous scale.

Obviously one element in this experiment which will have great weight—which may even be decisive—is the willingness of employers to cooperate even at considerable risk to their own finances. To assure this cooperation a strong public sentiment is being built up in favor of those who cooperate and antagonistic to those who do not. This public sentiment will probably not limit itself to demanding merely literal observance of the voluntary blanket agreement proposed by the President. It will almost surely look with disfavor upon all employers who demand long hours from their employees.

Hospitals and other social agencies therefore will probably find it advantageous to consider the matter of hours for nurses as a problem in public relations as well as a problem in financing and administration. It would be unfortunate if the splendid popular appreciation of these agencies which has been built up through their wholehearted public service during the depression should be dissipated because they found themselves unable or unwilling to give to their nurses as good working conditions as are being demanded for cooks, janitors and orderlies. The present voluntary movement among such agencies to shorten nurses' hours will undoubtedly receive considerable impetus from NRA publicity.

Is the Auto Accident Problem Hopeless?

IN SPITE of the extended discussion among hospital people and the obvious character of the wrong, hospitals continue to be seriously imposed upon by the care of automobile accident cases for which they are able to collect little or nothing. The problem stands out clearly. A real solution apparently is yet to be found.

Experience is leading hospital executives to the conclusion that adequate compensation for the care of automobile victims will not be received from the victims themselves, many of whom are innocent sufferers. Nor is it forthcoming in many cases from the other parties concerned or their insurance companies. The victim if innocent naturally does not want to pay for hospitalization and medical service since he is also losing time from his work and suffering physical pain. The driver or the insurance company does not want to pay for hospitalization, not only because of the money directly involved but also for fear that such payment will be a prima facie admission of responsibility.

If the hospital is to look to some insurance fund for its payment, and that seems the only safeguard nowadays when so many cars are driven by persons with little or no financial responsibility, then the hospital's right of recovery should not have to depend upon disputed questions of law and fact as to the liabilities of the various parties to an accident with which the hospital had no concern.

England has taken a few faltering steps toward remedying this situation by legislative action. The Road Traffic Act of 1930, according to Sir Charles Harris, embodied the principle of insur-

ance for the hospital's benefit, though on severely restricted lines. Hospital recovery under the act was limited to (a) cases in which compensation was actually paid under the policy by the insurer, (b) in-patients only at the average cost for all in-patients (thus excluding any fees for physicians), and (c) a maximum of about $125 for any in-patient. The benefits to hospitals under this law have been negligible, the total recovery in 1931 being only £34,000 as compared with £26,000 in 1927 while the cost to the hospitals of caring for auto accident cases was about the same in each year (£230,000).

To remedy these defects a new bill has been introduced in Parliament which adopts a basic principle analogous to workmen's compensation. Under the new bill compensation for bodily injury would be recoverable by the victims of a motor accident without proof of negligence on the part of the driver of the motor, or of the absence of contributory negligence on the part of the victim, unless the latter by his own negligence, or some third person, is shown to be wholly responsible for the accident. Though not mentioning hospitals, this bill, if passed, will undoubtedly benefit them, since compensation would be payable in cases of pure accident and payment to the hospital would then follow under the existing act.

The victim of an automobile accident, especially if he be a pedestrian, is in a very poor position to prosecute a claim for damages. It is obviously difficult to produce independent witnesses to an event that happened in the twinkling of an eye, often on a lonely stretch of road or in the dark. Where responsibility cannot be established between the pedestrian and the motorist, it is only fair that the person who receives the benefit from operating the potentially dangerous machine on the public highway should be the one to pay the costs of its operation—and these costs include the cost of caring for the victims of auto accidents. Certainly the limited funds which most hospitals have for the care of the indigent should not be consumed by a burden which rightly belongs on the shoulders of the motoring public.

While the very sensible recommendations made last year by the committee on workmen's compensation and liability insurance of the American Hospital Association will undoubtedly assist hospitals to collect from patients who are financially responsible, they obviously do not meet the numerically more important problem of collecting when the patient is not able to pay. Nor will lien laws help in the 70 per cent or more of cases where there is no liability insurance. Three possible solutions of this latter problem suggest themselves:

1. Add either a fixed sum of, say, $1 to the motor vehicle tax or a fraction of a cent to the gasoline tax, the proceeds of which will be used by the state to pay hospitals for the care of automobile accident cases.

2. Inaugurate compulsory automobile insurance and remove the common law defenses of contributory negligence, at least insofar as they apply to the recovery of hospital fees (which might be done without prejudice to the defense of a suit for damages for suffering and time lost from work).

3. Include hospital care for automobile accidents, regardless of the patient's length of stay, as a benefit of group hospitalization.

The first two proposals would put the expense of automobile accidents upon the automobile-using public. The last would place it upon the injured person. Only the first would cover the case of the injured person who is also the driver of the car and is wholly responsible for the accident.

The subject seems to be of sufficient importance to merit further study by the Insurance committee of the American Hospital Association.

Are Training Schools Necessary?

THE public is told that there are too many nurses. Young women are discouraged to prepare for this profession with the warning that their services will not be required when they have finished their training. Many persons believe, however, that there is not a surplus of well trained graduate nurses. No doubt there is a surplus of poorly trained nurses.

Lack of standardization in teaching methods and in clinical material has made it impossible to interpret properly in terms of efficiency the R.N. degree. The hospital must have nurses. Institutions unable to offer an adequate training course, however, should be prevented from profiteering on the confidence of young women desiring to fit themselves for this profession. Institutions in which graduate nurses care for patients lack the splendid educational atmosphere present in hospitals that maintain high grade training schools. Some training schools are not necessary, but all high grade schools are of the utmost importance both to the hospital with which they are affiliated and to the public served by their graduates.

The situation would have been largely clarified had the committee recently studying this subject boldly expressed its opinion as to minimum curricular standards. Schools unable to meet these requirements would then have gradually relinquished their claims of excellence and schools offering suitable courses would have found themselves greatly strengthened.

The Problem of the Month

Should Anesthetics Be Given Only by Doctors and Dentists?

THE Medical Society of the State of New York has adopted a resolution urging that the giving of anesthetics by nurses and lay technicians be discontinued because (1) this violates the medical practice act of the state, (2) it usurps the rights of the licensed physicians, (3) it is not safe because surgeons rarely select or examine the qualifications of anesthetists and (4) it deprives interns and residents of opportunity for instruction in this field.

Some hospital administrators, on the other hand, are convinced that well trained nurses or lay anesthetists are more competent to give anesthetics than most physicians, that the expense to the patient is considerably less, and that physicians do not like to give anesthetics.

Which position seems the more desirable to you?

Dr. Harry D. Clough, Acting Medical Director, Rochester General Hospital, Rochester, N. Y.:

"It seems to me that the primary consideration in this matter is the safety of the patient. There is no excuse for omitting any safeguards in the way of qualifications—particularly in hospitals. Hospital authorities can be in a position to vouch for the credentials of anesthetists just as much as for those of members of the regular staff. Experience has amply demonstrated that nurses, when properly selected and trained, can administer certain types of anesthetics as safely and satisfactorily as can physicians.

"The administration of anesthetics is, in my opinion, primarily a physician's responsibility. Every possible encouragement should be given to physicians who wish to specialize in anesthesia or do research work in this field.

"I feel that the department of anesthesia in a hospital should be in charge of and actually supervised by a physician who has specialized in this field. If he sees fit to train some specially qualified nurses to assist in the work of his department, under his direct supervision, I can see no objection to it. Obviously nurses have a somewhat limited sphere in this field since they are practically limited to the administration of ether and certain forms of gas anesthesia. Naturally they would not be permitted to administer intravenous anesthetics and probably would not give spinal or caudal anesthesia or do the various forms of nerve blocking.

"I do not feel that the argument relating to the instruction of interns and residents is a strong one as it is presented in the resolution. Interns and residents should be instructed in the administration of anesthetics and this is possible under many different types of organization of the department. There is no validity to the argument that physicians are necessarily better anesthetists than nurses and it is really the ability of the anesthetist which is the chief consideration in the teaching of interns.

"This resolution appears to be an attempt to prevent the invasion of the field of medicine by others than those with medical training. From this angle it should receive support both from the standpoint of protecting the physicians and that of safeguarding the public. I imagine that the anesthetists view this new movement as an opening wedge for other similar invasions of the field of medicine."

R. W. Nelson, Manager, Portland Sanitarium & Hospital, Portland, Ore.:

"This question has been up for discussion on our staff a number of times. Our most prominent surgeons have expressed themselves most emphatically that they believe a well trained nurse anesthetist is just as well qualified to administer anesthetics as is the medical practitioner. I take the liberty of quoting Dr. W. B. Holden on this question. Doctor Holden does a great deal of major surgery, and he says that he much prefers to have a nurse anesthetist who is well trained. His logic is that any doctor giving an anesthetic is bound to be more interested in the case than in the anesthetic, that his attention is likely to be diverted

to the surgical procedure, whereas the nurse anesthetist gives her undivided attention to the anesthetic procedure.

"How the hospital finances would be affected by having all anesthetics given by physicians, I think, is of secondary importance. The primary consideration in any question of this kind is the welfare of the patient. I do not think the hospital finances would be greatly affected except that it would be just one more step in making it that much nearer impossible for the patient to pay for his illness. Naturally the physician anesthetist will charge a fee for his services, and undoubtedly it will be a much higher fee than is now being charged by the hospitals employing nurse anesthetists, thus adding one more burden to the patient who is already heavily overburdened when he meets the problem of paying the hospital and the doctor who attended him in a case requiring surgical attention. Frankly, I am opposed to any new plan that adds further financial burdens to the patient.

"If the patient is actually better off by having a physician give the anesthetic, I presume he should be happy to pay an additional fee. I doubt very much whether the results obtained will be any different, whether the anesthetic is administered by a nurse or by a physician. We have always had specially trained nurse anesthetists given anesthetics in our institution."

Dr. Henry Hedden, Superintendent,
Methodist Hospital, Memphis, Tenn.:

"The problem of replacing nurse anesthetists with licensed physicians is an interesting one. Judging by the present indications, if none but physicians were allowed to give anesthetics in Memphis hospitals, there would be practically no anesthetics given. The hospitals of Memphis employ twelve or fifteen anesthetists, all of whom have had much more training in that field than most doctors. The experience of some of these women covers thousands of successful anesthesias. As a whole, the members of the Memphis Anesthetists Association represent a splendid body of earnest, intelligent, well trained women.

"The development of the nurse anesthetist is a result of the unwillingness of physicians to give anesthetics. There are probably not over a half dozen doctors in Memphis who would give an anesthetic by choice. For that very reason, the surgeons and obstetricians have been compelled to develop a corps of so-called lay anesthetists.

"There are some states that do not permit anesthesias by anybody but licensed physicians or dentists. Fortunately, Tennessee is not among those states. I am sure that the patient, a rather important person whose interests are sometimes overlooked, has a much better chance of recovery from an anesthetic administered at the hands of a competent anesthetist than if given by a licensed physician whose training and experience might be less broad.

"So far as I know, there has been no agitation in this particular section of the state for replacing nurse anesthetists."

G. W. Olson, Assistant Superintendent,
Los Angeles County General Hospital, Los Angeles:

"The administration of anesthetics should be limited to licensed physicians and dentists. A license alone, however, is not enough; additional training is necessary just as in other branches of medicine. This is the only way the quality of the work can be improved and further advancement made.

"Hospitals should have a physician on full-time with special training in anesthesia in charge of the department. He can then instruct the residents and interns and supervise their work. His salary will be the only expense to the hospital.

"This arrangement is particularly applicable to publicly owned institutions. Private hospitals may have either an open or closed staff in anesthesia, according to the custom of the other services of the institution. This system adds no expense to the hospital.

"The slightly higher anesthetic fee the patient has to pay for the service of the physician anesthetist is more than equalized by the additional safety given to his life during surgery and during the period of convalescence."

Sister St. Beatrice, Superior,
Oak Park Hospital, Oak Park, Ill.:

"We believe that, as a rule, anesthetics should be administered by a licensed physician or dentist, as they have more knowledge of the general and particular condition of a patient and can more easily detect unfavorable symptoms, and they know better what to do in case of emergency.

"However, we do not disapprove entirely the giving of anesthetics by a good technician—a graduate nurse, for instance, who has had thorough postgraduate training in this work. We employ both a physician and a technician and have never had an accident. Some of our Sisters who are well qualified in this respect are often called upon to administer anesthetics.

"In a time of depression, such as we have been passing through, not many hospitals are able to pay a number of physicians for this work; if they can afford one person who has the general supervision and responsibility, they are fortunate."

Dispensary Practices That Need Regulation

By

E. M. BLUESTONE, M.D.

Director, Montefiore Hospital, New York City

EVERYTHING that has value in terms of money is being subjected more and more closely to scrutiny these days on the chance that the prevailing desperate economic situation may be relieved by doing away with certain expenditures and reducing others. In times of economic stress the struggle for existence becomes more acute and in an endeavor to ensure their survival men are apt to compromise with their ideals. Medical service is a case in point.

Until the advent of the financial earthquake four years ago, patients who could afford to do so went to the offices of the practitioners, while others, who were almost if not entirely destitute, threw themselves on the generosity of the private philanthropy of organized clinics. There were, naturally, exceptions in both instances. Such an arrangement might have continued to succeed if adverse financial circumstances had not laid such a heavy hand on clinic, patient and doctor.

Private group treatment accordingly came into vogue in response to the requirements of the times, stimulated by the example set in the hospital and in its out-patient department. This practice in turn increased the cost of medical service somewhat and, with the depression as a good excuse, more and more patients found their way into public dispensaries.

The dispensary that dealt with large numbers of patients—often more than it could serve—either could not or would not, because it was too troublesome and too expensive, look into the financial eligibility of each patient. Some patients gained entrance in this way who should have applied for treatment at the office of the practitioner. In some states, as in New York, there is a dispensary law on the statute books which, theoretically at least, should keep away from the dispensary patients who can afford private care. But the law has never been invoked.

Dispensaries generally have been successful in recruiting practitioners for the staff under the law of supply and demand. Men were indeed willing to serve without salary in return for practical experience and prestige, so long as they were able to make a living in their private offices, and it never occurred to them, except on rare occasions, to question the practices of the institution of which they were a part. Unfortunately there stole into the dispensary, as into the wards, a "holier than thou" attitude toward the practitioner but since the era was a prosperous one the situation was tolerated by the profession with an attitude of surprise and indifference. Some dispensaries, in defiance of the dispensary law, raised their admission fees to the point where they could no longer claim standing as philanthropic institutions. Thus the seeds of discord were sown.

The economic revolution that has now come upon us has aggravated the situation and three groups will have to get together soon around the council table if they want to settle their differences out of court—the patient, the dispensary and the practitioner. Of these three the patient should have the determining voice in the outcome. We could, of course, return to first principles, as we pointed out in these columns when the Crawford bill was under consideration by the New York State legislature, in which case (1) the existing law might be enforced to compel dispensaries, which had wandered, to return to the philanthropic fold and (2) the patient might be excluded from the dispensary if he is not entitled to the benefits of philanthropy. In the latter instance we could take our chances on the patient's acceptance of the alternative of visiting the office of the practitioner.

A Possible Solution to the Problem

The principle of a maximum noncompetitive dispensary fee, to be worked out locally by the institution and the medical profession jointly, will also have to be recognized. By controlling this fee, as well as by enforcing the dispensary law generally, the problem may be solved to the satisfaction of everyone concerned. The payment of a full or part-time salary for the dispensary services of the practitioner will not dispose of the problem until the time arrives when the dispensaries are able to do a complete job of it and take all of the practitioners into their employ.

It will be said, of course, that private philanthropy is dwindling away under our eyes and that dispensaries which depend on it to make good the difference between the contribution of the patient and the actual cost of his treatment, exclusive of the philanthropic contribution of the doctors' services, will not be able to carry the burden much longer if the default continues. This is another and a larger problem which we shall have to face at another time and from a broader and more fundamental angle, if and when circumstances demand that it is necessary to do so.

Record Breaking Attendance Expected at A. H. A. Convention

INDICATIONS are that the thirty-fifth annual convention of the American Hospital Association, meeting in Milwaukee from September 11 to 15, will have the largest attendance of any convention in the history of the association. Hospital people evidently feel that there is greater need now than ever before to share experiences.

The program is of a high type throughout. Special mention should be made of the excellence of the programs scheduled for the hospital income and expense section, the administration section, the out-patient department section and the round tables on small hospitals and hospital legislation. Many other section programs also deserve highest commendation.

While the effect on hospitals of President Roosevelt's recovery program is mentioned only once on the program, this subject will undoubtedly receive a great deal of attention. A special committee has recently been in Washington to discuss the question of a hospital code and its report is awaited with keen interest.

The report on Tuesday evening by the Council on Community Relations and Administrative Practice on its first year's work will be a high point of the program. The president's evening is scheduled for Monday and the annual banquet and ball will be held on Wednesday evening. Glenn Frank, president, University of Wisconsin, will be the banquet speaker. Another highlight of the convention will be the showing on Tuesday afternoon of the film, "Good Hospital Care," which has been prepared by the American College of Surgeons.

The commercial and educational exhibits will, as usual, present a varied and valuable picture of modern equipment and supplies and present day hospital practices.

Most of the committee reports will be presented at a general business session on Monday afternoon. Induction of new officers will take place Friday.

Dr. George F. Stephens, Winnipeg, Man., president of the association.

Dr. Nathaniel W. Faxon, Rochester, N. Y., president-elect of the association.

Program of A. H. A. Convention

Dietetic Section

Monday afternoon, September 11

Chairman, Mary M. Harrington,
Harper Hospital, Detroit.
Secretary, Mable MacLachlan,
University Hospital, Ann Arbor, Mich.

Greetings of the American Hospital Association by Dr. George F. Stephens, president, American Hospital Association.
Greetings of the American Dietetic Association to the dietetic section of the American Hospital Association: Dr. Kate Daum, president, American Dietetic Association, department of nutrition, Iowa State University Hospital, Iowa City.
Food Costs and Comparison: Faith McAuley, Universtiy of Chicago.
Food Waste: Lenna Cooper, Montefiore Hospital, New York City.
Study of Raw Food Cost and Service Costs in a Selected Group of Hospitals: Mable MacLachlan, University Hospital, Ann Arbor, Mich.
Pertinent Economies in the Food Department: Paul H. Fesler, superintendent, Wesley Memorial Hospital, Chicago.

President's Evening

Monday evening, September 11

Address: Dr. George F. Stephens.
Conferring of National Hospital Day Award by Veronica Miller, chairman, National Hospital Day Committee, Henrotin Hospital, Chicago.

Tuberculosis Section

Tuesday morning, September 12

Chairman, Dr. Bruce H. Douglas,
William H. Maybury Sanatorium, Northville, Mich.

Cooperation Between the Sanatorium and the General Hospital and the Place of the General Hospital in the Tuberculosis Field: Dr. A. T. Laird, superintendent, Nopeming Sanatorium, Nopeming, Minn.
The Relation Between the Death Rate From Tuberculosis and the Number of Sanatorium Beds in the Provinces of Canada: Dr. Madge Thurlow Macklin, University of Western Ontario, London, Canada.
The Liability of Sanatorium or Hospital for Employees Who Develop Tuberculosis While Employed: Dr. Walter Rankin, Dane County Sanatorium, Madison, Wis.
Education Work and Occupational Therapy: Dr. Glenford L. Bellis, superintendent, Muirdale Sanatorium, Wauwatosa, Wis.

Round Table

Tuesday morning, September 12

Leader, Dr. Malcolm T. MacEachern,
American College of Surgeons, Chicago.

Report of Public Relations Committee: Dr. Malcolm T. MacEachern, chairman.

Round Table

Tuesday morning, September 12

Leader, Dr. Warren L. Babcock,
Grace Hospital, Detroit.

Will the Human Urge to Give to Those Less Favored Continue for Voluntary Hospitals? Dr. Donald M. Morrill, director, Blodgett Memorial Hospital, Grand Rapids, Mich.
Strengthening of Credit Investigator's Department: Dr. Walter S. Goodale, superintendent, Buffalo City Hospital, Buffalo, N. Y.
New Methods of Salvaging Unpaid or Credit Accounts: James R. Mays, superintendent, Elizabeth General Hospital and Dispensary, Elizabeth, N. J.
(a) Cost of Maintaining Preliminary Student Nurses and (b) The Hospital Finance Corporation of Cleveland: Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland.
Salvaging Operations as a Hospital Saving: Dr. Lucius R. Wilson, superintendent, John Sealy Hospital, Galveston, Tex.
New Income and Old Expenditures: Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn.

Administration Section

Tuesday afternoon, September 12

Chairman, George D. Sheats,
Baptist Memorial Hospital, Memphis, Tenn.
Secretary, A. M. Calvin,
Midway and Mounds Park Hospitals, St. Paul, Minn.

Report of the Committee to Study the Reports of the Committee on the Cost of Medical Care: Dr. Michael M. Davis director, Julius Rosenwald Fund, Chicago.
Discussion: Dr. J. G. Sargent, president, Milwaukee County Medical Society, Milwaukee.
Taxpayers, Politicians and the Indigent Sick: Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y.
Discussion: William L. Coffey, manager, Milwaukee County Institutions, Wauwatosa, Wis.
Brevities on the Psychology and Mechanics of Institutional Purchasing: Dr. B. Henry Mason, superintendent, Waterbury Hospital, Waterbury, Conn.
Discussion: Robert E. Neff, administrator, University of Iowa Hospital, Iowa City.
Southern Hospitals, Their Development and Problems: Dr. Lucius R. Wilson, superintendent, John Sealy Hospital, Galveston, Tex.
Discussion: Dr. W. S. Rankin, director, the Duke Endowment, Charlotte, N. C.
The Vital Value of Research in Hospital Administration: John A. McNamara, New York City.

Technical Section

Tuesday afternoon, September 12

Presiding, Dr. B. W. Black,
Vice President, American Hospital Association.

Obtaining Normal Sleep for the Average Patient: Dr. Donald A. Laird, Psychological Laboratory, Hamilton, N. Y.
The Hospital Laundry: Walter Reinhard, department of engineering, Laundry-Owners National Association of the United States and Canada, Joliet, Ill.
Food and the Patient: George Rector, world authority on the preparation and serving of foods.
Textiles for Hospital Use: Prof. Arthur A. Stewart, head of finishing department, Lowell Textile Institute, Lowell, Mass.
Insurance for the Hospital: by a representative of the National Bureau of Casualty and Surety Underwriters.

Council on Community Relations and Administrative Practice and Trustees' Section

Tuesday evening, September 12

Chairman Dr. S. S. Goldwater,
Trustee, Mt. Sinai Hospital, New York City.

The Aims of the Council on Community Relations and Administrative Practice: Dr. S. S. Goldwater.
The Contribution of Local Hospital Councils and Near Councils to Hospital Efficiency and Community Planning: Dr. G. Harvey Agnew, secretary, department of hospital service, Canadian Medical Association, Toronto, Ont., Can.
Report of the Council's Division on Hospital Medical Practice: Dr. R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison.
Report of the Council's Division on Hospital Accounting: Dr. Basil C. MacLean, superintendent, Touro Infirmary, New Orleans.
Report of the Council's Division on Nursing: Dr. C. W. Munger.
What the Periodic Payment Plan for the Purchase of Hospital Care Has Thus Far Demonstrated: C. Rufus Rorem, Julius Rosenwald Fund, Chicago.
Discussion: Dr. Frederic A. Washburn, director, Massachusetts General Hospital, Boston.
Discussion: Rev. Maurice F. Griffin, Cleveland.

Social Service Section

Wednesday morning, September 13

Chairman, Babette Jennings,
Children's Memorial Hospital, Chicago.
Secretary, Gertrude Smith,
Butterworth Hospital, Grand Rapids, Mich.

Greetings from the president of the American Hospital Association.
A Summary of Present Typical Problems as Reported by a Group of Departments: Babette Jennings, director, social service department and dispensary, Children's Memorial Hospital, Chicago.
Discussion: Mrs. Charles W. Webb, director of social work, University Hospitals, Cleveland; Elizabeth McConnell, director, Mandel Clinic, Michael Reese Hospital, Chicago; Marguerite Spiers, director of social work, Alameda County Department of Health and Hospitals, Oakland, Calif.; Bess Glassman, director of social work, Jewish Hospital, St. Louis; Lucille M. Smith, supervisor of medical services, Cook County Bureau of Public Welfare, Chicago, and Dr. Michael M. Davis.

Round Table

Wednesday morning, September 13

Leader, Dr. Lewis A. Sexton,
Hartford Hospital, Hartford, Conn.

How Can Interference by the Board of Directors With the Administration of the Hospital Be Prevented?
Should the Superintendent Attend All Meetings of the Board of Trustees?
Discussion open by: Dr. C. W. Munger.
How Can the Public Be Educated as to the Cost of Good Hospital Service?
What Should Hospital Superintendents Do to Increase Their Endowment?
Discussion opened by: Dr. Allan Craig, director, Charlotte Hungerford Hospital, Torrington, Conn.
When the Patient Says He Can Only Pay a Part of His Hospital Bill on Discharge, Is It Customary to Require Him to Sign a Note?
What Success Have You Had in the Use of Loan Banks in Installment Payments of Patients' Accounts?
Discussion opened by: Dr. Warren L. Babcock, director, Grace Hospital, Detroit.

Round Table

Wednesday morning, September 13

Leader, Dr. Donald C. Smelzer,
Graduate Hospital of the University of Pennsylvania, Philadelphia.

Subject: Purchase and Use of Supplies.

Nursing Section

Wednesday afternoon, September 13

Chairman, Dorothy Rogers,
John Sealy Hospital, Galveston, Tex.
Secretary, Carolyn E. Davis,
Good Samaritan Hospital, Portland, Ore.

Nursing for Hospital Service: Elnora Thomson, president, American Nurses Association, New York City.
General discussion.
Nursing Profession Works for Recovery: Emilie G. Sargent, chairman, committee nursing distribution, American Nurses Association, New York City.
General discussion.
The Hospital Administrator as an Explorer in the Field of Nursing: Robert E. Neff, administrator, University of Iowa Hospital, Iowa City.
General discussion.

Out-Patient Section

Wednesday afternoon, September 13

Chairman, John E. Ransom,
Johns Hopkins Hospital, Baltimore.
Secretary, Ray Amberg,
Hospital Manager, Students' Health Service, University of Minnesota.

Report of the Out-Patient Committee: Dr. Frederick MacCurdy, Vanderbilt Clinic, New York City, chairman.
The Forces at Work in the Development of the Out-Patient Department and Their Relation to Today's Problems: Dr. James W. Manary, director, out-patient department, Boston City Hospital, Boston.
Does Your Hospital Need an Out-Patient Department? Dr. Frederick MacCurdy, Vanderbilt Clinic, New York City.
What Factors Should Determine the Need and Size of an Out-Patient Service in the Community? Dr. Stewart Hamilton, director, Harper Hospital, Detroit.
Home Service From the Out-Patient Department, Medical, Nursing, Social and Relief: Dr. Robert Nye, director, Curtis Clinic, Jefferson Medical College Hospital, Philadelphia.
The Out-Patient Department as a Consultation Service: Dr. Samuel Bradbury, medical director, out-patient department, Pennsylvania Hospital, Philadelphia.
Topics for general discussion:
(a) Community Relationships of an Out-Patient Department.
(b) Who Should Pay the Hospital and Doctors Where Funds Are Inadequate to Meet the Needs and on What Basis?

Hospital Topics Section

Wednesday afternoon, September 13

Presiding, Dr. Stewart Hamilton,
Vice President, American Hospital Association.

All-Inclusive Rates in Hospitals: Dr. Paul Keller,, superintendent, Newark Beth Israel Hospital, Newark, N. J.
Open and Closed Professional Staffs in Hospitals: Dr. A. K. Haywood, superintendent, Vancouver General Hospital, Vancouver, Canada.
Obstetric Problems of the Small Hospital: Dr. A. J. Skeel, director, division of obstetrics, St. Luke's Hospital, Cleveland.
Value of the Work of a Central Statistical Bureau: Carolin Martin, director, Central Statistical Bureau, department of hospitals, New York City.
The Saskatchewan Hospital Plan: Leonard Shaw, general superintendent, Saskatoon City Hospital, Saskatoon, Canada.
The Library in the Hospital: Dr. Frederic A. Washburn.

Children's Hospital Section

Thursday morning, September 14

Chairman, Dr. Herman Schumm, Milwaukee.
Secretary, Sophie Yoerg,
Milwaukee Children's Hospital, Milwaukee.

Orthopedic Treatment in Infantile Paralysis: Dr. W. Blount, Milwaukee Children's Hospital, Milwaukee.
The Social Service Department in a Children's Hospital—The Importance to the Hospital and to the Community: Theodate Soule, head social worker, pediatric service, Washington University Clinics, St. Louis.
Thursday afternoon will be devoted to a visit to Children's Hospital and Convalescent Home, Milwaukee.

Round Table

Thursday morning, September 14

Leader, Dr. G. Harvey Agnew,
Department of hospital service, Canadian Medical Association, Toronto.

Problems of Administration: (a) Is it feasible to consider a closer linking up between small rural hospitals and large urban hospitals? In what way could this be effected? (b) What are the best means of leading the less active trustees to more fully appreciate their obligations and the hospital's problems and opportunities? (c) Where municipal aid for the care of indigents is available should hospitals enter into "contracts" with local authorities at reduced rates? (d) To what extent, if any, should the superintendent of the smaller hospital assume other than purely administrative duties?
Problems of Medical Relationship: (a) What is the best method of obtaining expert oversight of the radiological and pathological departments in the small hospital? (b) To what extent should hospitals encourage medical staff organization and medical activities? (c) What is the best way of developing in the medical staff a greater appreciation of, and interest in, the general problems of hospital administration? (d) Should nurses be permitted to remove drainage tubes?
Problems of Public Relationship: (a) To what extent should small hospitals develop out-patient departments? (b) To what extent can the hospital broaden its contribution towards improving the community health? (c) How are the smaller hospitals meeting the needs of the community for cheaper accommodation? (d) How rigidly should rules respecting visitors be maintained?

Round Table

Thursday morning, September 14

Leader, Dr. R. C. Buerki,
State of Wisconsin General Hospital, Madison.

Report of the Legislative Reference Committee: Dr. J. L. McElroy. This round table, conducted by Doctor Buerki, will follow the discussions presented on hospital legislation from the floor. Among the subjects that will be given particular attention are:
Hospitals as Affected by the NRA.
Automobile Accident Legislation.
Sales Tax as It Affects Hospitals.
Processing Tax as It Affects Hospitals.
Hospital Lien Laws.

Construction Section

Thursday afternoon, September 14

Chairman, Dr. C. W. Munger,
Grasslands Hospital, Valhalla, N. Y.
Secretary, H. Eldridge Hannaford,
Samuel Hannaford & Sons, Architects, Cincinnati.

Planning the Nurses' Home: Austin D. Jenkins, Puckey and Jenkins, architects, Chicago.
Discussion: Dr. George O'Hanlon, administrating officer in charge, Jersey City Medical Center, Jersey City, N. J., and Mabel Binner, superintendent, Children's Memorial Hospital, Chicago.
Report of the Committee on Hospital Planning and Equipment: Chairman, Dr. Lucius R. Wilson, superintendent, John Sealy Hospital, Galveston, Tex.
Discussion: Charles F. Neergaard, trustee, Carson C. Peck Memorial Hospital, Brooklyn, N. Y.
The Hospital Corridor: Dr. S. S. Goldwater, trustee, Mt. Sinai Hospital, New York City.
Discussion: Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn.
Planning the Operating Suite: Dr. L. H. Burlingham, superintendent, Barnes Hospital, St. Louis; Wilbur T. Trueblood, architect, St. Louis, and Dr. E. A. Graham, surgeon-in-chief, Barnes Hospital, St. Louis.
Discussion Carl A. Erikson, architect, Chicago.

Small Hospital Section

Thursday afternoon, September 14

Chairman, W. Hamilton Crawford,
South Mississippi Infirmary, Hattiesburg.
Secretary, Edna D. Price,
Emerson Hospital, Concord, Mass.

The Oregon Plan of Prepaid Medical and Hospital Care: Alden B. Mills, The Modern Hospital, Chicago.
Are Hospital Publications Actually Meeting the Requirements of the Small Hospitals? Lee C. Gammill, superintendent, Baptist State Hospital, Little Rock, Ark.
The Hospital Publisher's Desire in Serving the Small Hospital: Matthew O. Foley, *Hospital Management*, Chicago.
General Discussion and Submission of Questions From the Floor: Leader, Dr. R. C. Buerki.

Teaching and Public Hospital Section

Thursday evening, September 14

Chairman, William L. Coffey,
Milwaukee County Institutions, Wauwatosa, Wis.

Report of Committee on Public Health Relations: Chairman, Dr. A. J. Chesley, state health department, St. Paul Minn.

General Session

Friday morning, September 15

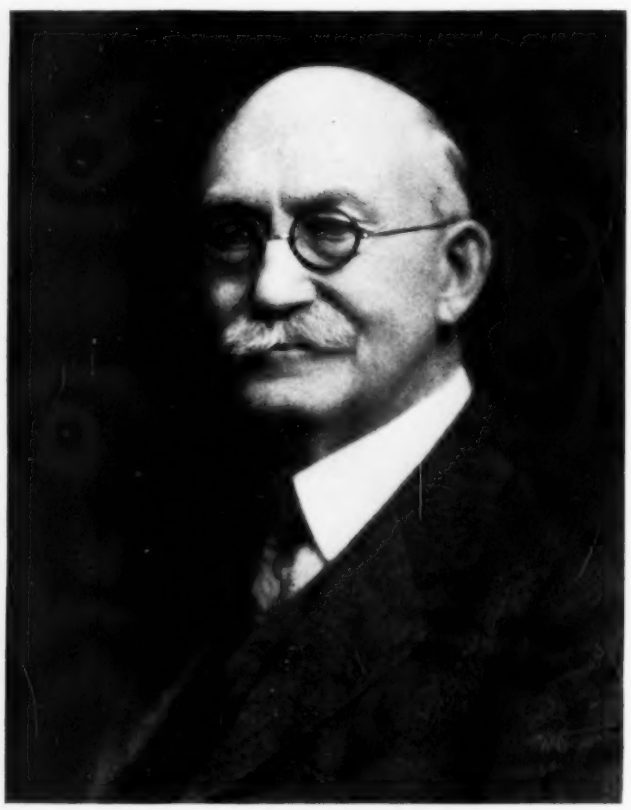
Presiding, Dr. George F. Stephens, president.
Induction of new officers. Unfinished business. New business.

College of Surgeons Plans 16th Standardization Conference

A WELL balanced, practical program has been prepared for the sixteenth annual hospital standardization conference of the American College of Surgeons, to be held in Chicago, October 9 to 12, inclusive. Provision is made on the program for addresses and discussion by hospital superintendents, nurses, surgeons and social service workers.

Dr. J. Bentley Squire, president of the College of Surgeons, and professor of urology, Columbia University College of Physicians, will preside at the opening session and will deliver the address of welcome.

The report of the sixteenth annual hospital standardization survey and the official announcement of the 1933 list of approved hospitals will be presented by Dr. Franklin H. Martin, Chicago, director general, American College of Surgeons. "The Hospital Standardization Movement in Relation to the Practice of Internal Medicine" is the subject of an address to be delivered by Dr. Walter L. Bierring, Des Moines, Iowa, president-elect, American Medical Association.



Dr. Walter L. Bierring, who will address the conference.

A round table conference will be held Monday afternoon on medical and hospital economics. Dr. Robert B. Greenough, assistant professor of surgery, Medical School of Harvard University, will preside. The subject will be discussed from the standpoint of the surgeon, the internist, the specialist, the radiologist, the pathologist and the hospital management.

An interesting session has been planned for Tuesday morning. The presiding officer will be Dr. Alexander B. Munroe, professor of surgery, University of Alberta, Edmonton. Subjects that will be covered at this session include standardization in the small hospital; hospital annual reports; convalescent care of the patient; the anesthesia department; the clinical laboratory.

Tuesday afternoon there will be demonstrations and round table conferences in local hospitals, dealing with departmental organization, management and functioning. Subjects to be discussed include: business methods in hospitals; admitting and discharging patients; the dietary department and food service, and operating room management and procedures.

Demonstrations at Local Hospitals

On Wednesday morning there will be a joint conference of the hospital standardization conference, American College of Surgeons and the Association of Record Librarians of North America. R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison, will preside. Problems associated with the obtaining of good clinical records in hospitals will be discussed.

Round tables will be held in the afternoon dealing with management of the clinical record department; nursing care of the patient; management of the obstetrical department, and management of the central supply room. These round tables will be held in local hospitals.

Social problems affecting hospitals will be discussed at a round table on Thursday morning. In the afternoon there will be demonstrations and conferences in local hospitals dealing with organization and management of the social service department, the intern service and the housekeeping department. Public relations will also be discussed. The Thursday morning round table will be conducted by Robert Jolly, superintendent, Memorial Hospital, Houston, Tex., and R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison. A sound motion picture will be shown on Thursday morning. The picture will illustrate what actually constitutes modern, scientific care of the patient.

Protestant Hospital Group Tells Convention Plans

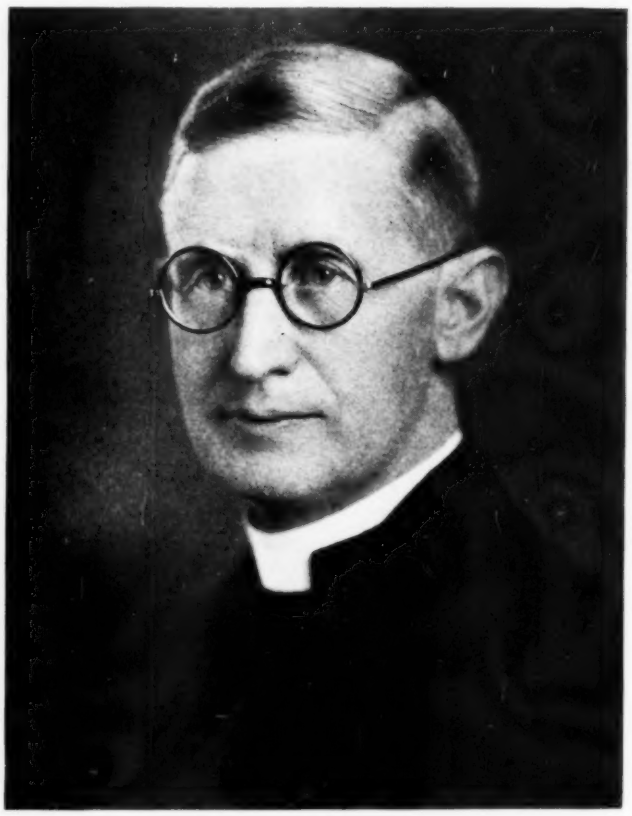
WITH a program that strikes one interesting spot after another, the thirteenth annual convention of the American Protestant Hospital Association gives promise of drawing a large attendance. The convention will be held in the New Phister Hotel, Milwaukee, on September 8, 9, 10 and 11.

The opening session will be called to order at 2 p.m. Friday afternoon, September 8, by Rev. Dr. Thomas A. Hyde, superintendent of Christ Hospital, Jersey City, N. J., president of the association. Rev. Paul Wendt, Evangelical Deaconess Hospital, Milwaukee, will conduct the opening devotions. Robert Jolly, Memorial Hospital, Houston, Tex., will serve as song leader for the convention.

A Symposium on Scientific Progress

"The Hospital's Major Economic Problems" will be presented by Ray A. Nettleton, Iowa Methodist Hospital, Des Moines. This will be followed by a symposium on "The Value to the Public of Scientific Progress of Hospitals" conducted by C. S. Pitcher, hospital consultant, Philadelphia. The following addresses will comprise the symposium: "Service—The Greatest Moment in Hospital Activity" by John H. Olsen, Richmond Memorial Hospital, Prince Bay, Staten Island, N. Y.; "Rebuilding the Hospital" by Benjamin S. Hubbell, architect, Cleveland; "Occupancy in the Hospitals" by J. Dewey Lutes, Ravenswood Hospital, Chicago, and "How the Hospital Benefits From a Program of Public Relations" by Paul H. Fesler, Wesley Memorial Hospital, Chicago.

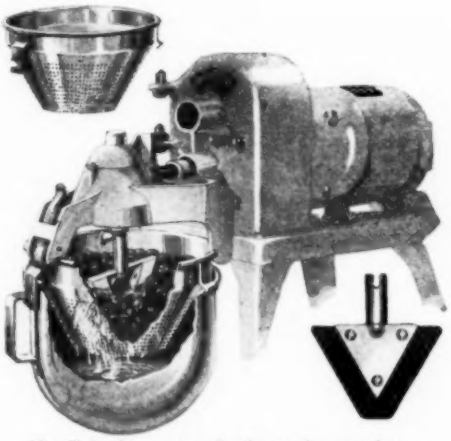
E. E. King, Missouri Baptist Hospital, St. Louis, will conduct a round table on "How to Obtain Economies From the Staff, Laboratories, X-Ray and Drug Departments." The following persons are expected to take part in this round table: T. J. McGinty, Southeast Missouri Hospital, Cape Girardeau, Mo.; A. E. Paul, Englewood Hospital, Chicago; E. M. Collier, West Texas Baptist Sanitarium, Abilene; Mrs. Alice Taylor, All Saints Hospital, Ft. Worth, Tex.; Miss F. Graves, Methodist Hospital, Peoria, Ill.; Geraldine Borland, Muskogee General Hospital, Muskogee, Okla.; Anna Bergeland, Lutheran Deaconess Home and Hospital, Minneapolis; Carolyn M. Fenby, Methodist Hospital, Madison, Wis.; E. I. Erickson, Augustana Hospital, Chicago; Dr. Charles S. Woods, St. Luke's Hospital, Cleveland; Dr. L. L. Andrews, Florida Sanitarium and Hospital, Orlando; Asa Bacon, Presbyterian Hospital, Chicago; C. I. Wollan, La Crosse Lutheran Hospital, La Crosse, Wis.; J. B. Franklin, Grady Hospital, Atlanta, Ga.; Rev. C. C. Haag, Evangelical Deaconess Hospital, Detroit; Lee C. Gammill, Baptist



Rev. Dr. Thomas A. Hyde, president.

State Hospital, Little Rock, Ark., and Dr. Louis J. Bristow, Southern Baptist Hospital, New Orleans.

The Friday evening session will open with music and an invocation by Rev. J. P. Van Horn of Cedar Rapids, Iowa. Dr. J. H. Bauernfeind, Evangelical Deaconess Hospital, Chicago, will discuss "Strengthening Protestant Institutions to Conserve Morals and Religion." The presidential address by Doctor Hyde will be on "Hospitality." Rev. Newton E. Davis, secretary of the Methodist Board of Hospitals, Homes and Deaconess Work of Columbus, Ohio, will present lantern slides to



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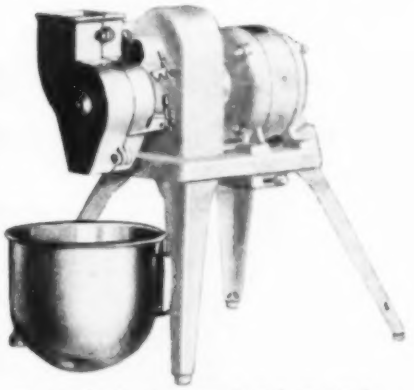
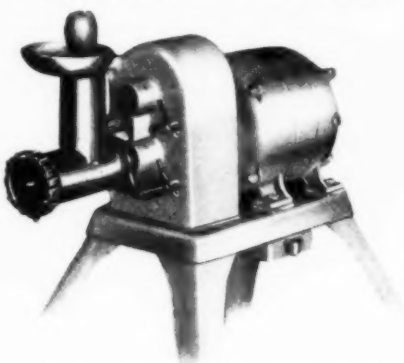
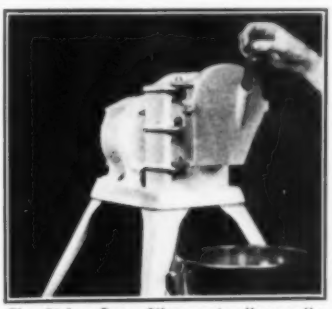


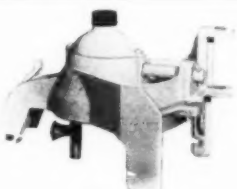
The Ice Crusher has utility both in the kitchen and also for ice packs. Merryway also offers a special Ice Shaver and Ice Cream Freezer.



The Food Chopper operates automatically—both hands are free. Numerous foods can be correctly served to meet modern dietary standards in hospitals.



The String Bean Slicer cuts diagonally to preserve flavor and speed cooking. This attachment is original in design and shows the great versatility of the Merryway.



MIXER HEAD

The Mixer Head is detachable instantly — an exclusive feature that greatly simplifies the operation of the Merryway and the attachments shown here.

ALUMINUM BEATER

DOUGH HOOK

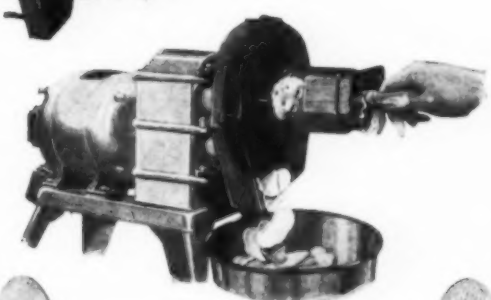
PASTRY KNIFE

WIRE WHIP

5-QT. MIXING BOWL

POURING CHUTE

MAYONNAISE OIL DROPPER



SLICER PLATE

The Slicer, Shredder and Grater has almost countless uses. Special plates, used with it, will slice, grate, shred, and prepare fruits and vegetables in many ways. (Merryway attachments also include a potato peeler, coffee mill, etc.)

GRATER PLATE

visualize the field of protestant hospital development and activities.

Group hospitalization will be the central topic for Saturday morning's discussion. Dr. Horace Agneu Johnson of Milwaukee will speak on "A Professional and Practical View of the Periodic Payment Plan" and Robert Jolly will conduct a round table on "The Benefits of Group Hospitalization, What Has Been Done, and How to Go About It." Mr. Jolly will be assisted by the following

C. S. Pitcher, president-elect.

superintendents who will tell what has been planned in their cities: A. M. Calvin, Midway and Mounds Park Hospitals, St. Paul; J. G. Norby, Fairview Hospital, Minneapolis; Rev. John G. Martin, Hospital of St. Barnabas and for Women and Children, Newark, N. J., and Dr. Herman Smith, Michael Reese Hospital, Chicago.

Those expected to take part in Mr. Jolly's round table are: O. B. Maphis, Bethany Hospital, Chicago; J. Dewey Lutes, Ravenswood Hospital, Chicago; Robert Neff, University of Iowa Hospital, Iowa City; Rev. L. M. Riley, Wesley Hospital, Wichita, Kan.; Edgar Blake, Jr., Methodist Hospital, Gary, Ind.; George Hays, Kentucky Baptist Hospital, Louisville; George Burt, Piedmont Hospital, Atlanta, Ga.; Jacob H. Trayner, Latter-Day-Saints Hospital, Idaho Falls, Idaho; Paul Zwilling, Evangelical Deaconess Hospital, St. Louis; George Sheats, Baptist Memorial Hospital, Memphis, Tenn.; Frank Shult, Methodist Hospital, Peoria, Ill.; J. C. Hiebert, General Hospital, Lewiston, Me.; Austin J. Shoneke, New Rochelle Hospital, New Rochelle, N. Y.; S. J. Barnes, United Hospital, Port Chester, N. Y.; W. Hamilton Crawford, South Mississippi Infirmary, Hattiesburg, Miss.; Albert G. Hahn, Protestant Deaconess Hospital, Evansville, Ind.; Paul H. Fesler, Wesley Memorial Hospital, Chicago; Rev. G. T. Notson, Methodist Hospital, Sioux City, Iowa; John A. McNamara, New York City; Matthew O. Foley, editorial director, *Hospital Management*, Chicago; Alden B. Mills, managing editor, The MODERN HOSPITAL, Chicago.

On Saturday afternoon Rev. Carroll H. Lewis, Christ Hospital, Cincinnati, will speak on "Saving Money Without Sacrificing Service."

An interesting feature of this session will be a consolidated report of all committees presented by J. B. Franklin, Grady Hospital, Atlanta, Ga. Mr. Franklin will give the high points of all reports.

An Interesting Round Table

"The Medical and Hospital Care of Negroes" is the subject of Rev. Will W. Alexander, Commission on Interracial Cooperation, Atlanta, Ga.

Dr. Malcolm T. MacEachern, director of hospital activities of the American College of Surgeons, will conduct Saturday afternoon's round table on "Administrative, Medical, Nursing, and Economic Problems of Our Hospitals." He will be assisted by the past presidents of the Protestant Hospital Association. They are: Rev. H. L. Fritschel, Milwaukee Hospital, Milwaukee; Charles S. Woods, St. Luke's Hospital, Cleveland; Rev. N. E. Davis, Methodist Episcopal Board of Hospitals, Columbus, Ohio; Robert Jolly, Memorial Hospital, Houston, Tex.; Rev. J. H. Bauernfeind, Evangelical Deaconess Hospital, Chicago; Rev. Luther Reynolds, Los Angeles; B. A. Wilkes, North Hollywood, Calif.; Rev. A. O. Fonkalsrud, Mansfield General Hospital, Mansfield, Ohio.

The annual banquet will be held Saturday evening at seven o'clock in the New Phister Hotel. Two outstanding addresses are scheduled for this occasion. The first is by Dr. George F. Stephens, president of the American Hospital Association on "What of the Future?" and the second is on "The Public's Interest in Hospital Care" by C. Rufus Rorem of the Julius Rosenwald Fund. A musical entertainment and the introduction of guests will also be featured.

The general program on Sunday evening is open to the public. Following devotions conducted by Rev. Raymond V. Johnson, Flower Hospital, Toledo, Ohio, Rev. Charles C. Jarrell, general secretary of the general hospital board of the Methodist Episcopal Church, South, Atlanta, Ga., will

speak on "Rethinking Hospital Practice in Human Reconstruction and Preservation." Dr. Willard C. Stoner, Cleveland, will discuss "The Hospital, the Doctor and the Part-Pay Ambulatory Clinic for the Middle Class Patient." Cornelia Van Kooy of the Wisconsin State Board of Health, Madison, will speak on "Frontier Nursing in Public Health."

The concluding session on Monday morning will be addressed by Dr. J. A. Diekmann, Bethesda Hospital, Cincinnati, on "A Newer and Better Day for Hospital Administrators." Lake Johnson, Good Samaritan Hospital, Lexington, Ky., will present "Economies in the Kitchen and Maintenance Departments." "Economies in the Housekeeping Department" will be offered by Susan E. Holmes, Abbott Hospital and Lydia A. Miller, Asbury Hospital, both of Minneapolis. John M. Smith, Hahnemann Hospital, Philadelphia, will discuss "The Community Hospital and the Community."

Monday's round table will be conducted by Guy M. Hanner, Beth-El Hospital, Colorado Springs, Colo. The discussion in this round table will be open to all delegates and visitors.

Mr. Hanner will be assisted by the following: Frank J. Walter, St. Luke's Hospital, Denver; Dr. Henry Hedden, Methodist Hospital, Memphis, Tenn.; Rev. John G. Benson, Methodist Hospital, Indianapolis; Margaret Parker, Epworth Hospital, South Bend, Ind.; Dr. B. M. Spurr, Reynolds Memorial Hospital, Moundsville, W. Va.; Rev. Frank Fowler, White Cross Hospital, Columbus, Ohio; Susan Schaeffer, Bismarck Hospital, Bismarck, N. D.; I. W. J. McLain, St. Luke's Home and Hospital, Utica, N. Y.; Stewart B. Crawford, Maryland General Hospital, Baltimore; Dr. J. P. Van Horn, St. Luke's Hospital, Cedar Rapids, Iowa; Henry Witham, Children's Hospital, Denver; Dr. J. A. Diekmann, Bethesda Hospital, Cincinnati; Rev. A. Matzner, Evangelical Deaconess Hospital, Marshalltown, Iowa; Rev. Philip Vollmer, Fairview Park Hospital, Cleveland, Ohio; Dr. C. C. Marshall, Methodist Episcopal Hospital, Brooklyn, N. Y.; Mrs. May A. Burgess, Committee on Grading of Nursing Schools, New York City; Mary A. Roberts, editor, *American Journal of Nursing*, New York City; Mrs. Meta Pennock Newman, editor, *Trained Nurse and Hospital Review*, New York City; Rev. Clinton F. Smith, Allen Memorial Hospital, Waterloo, Iowa, and Dr. W. F. Cook, New England Deaconess Hospital, Boston.

Early Morning Care of the Patient

By WILHELMINA L. BARRETT
New York State Department of Social Welfare

Frequent complaints reach the New York State Department of Social Welfare in regard to the early hour at which ward patients are awakened. In this connection it is interesting to give the experience of the French Hospital, New York City. For two years its rule has been that the day nurse shall awaken ward patients on her arrival at 7 a.m. An exception is made of course if a case is due in the operating room at an early hour or if special treatment has been ordered. Then the night nurse gives the required care.

The usual assignment for night work is one student nurse to a ward. This gives her varied duties and much responsibility. In order that morning care might be completed at seven o'clock, it was necessary to pass bedpans and hand basins between five and six o'clock, according to the number of patients in the ward. The work more often began at five than at six and all patients were disturbed at this early hour. Bathing of those not able to do it for themselves had to be done by the night nurse. Cleaning and putting utensils away followed. Then breakfast arrived, the nurse assisted the pantry maid and fed those requiring aid. Her's was a hectic rush and the patient seemed to be the victim. But now she gives only the special early morning treatments that may be ordered and attends carefully to all details in treatment and utility rooms that will expedite the duties of the day nurses.

Group assignment is in effect for day nurses. Normally each one is made responsible for four patients between the hours of 7 a.m. and 9 a.m.

With four patients under their care, the day nurses are expected to give two patients a full and two a partial bath daily, changing and making beds at the same time. They attend to other immediate needs and, when breakfast arrives around 7:45 o'clock, assist the pantry maid in serving patients now allowed to eat. Medicines and special treatments are then given and patients prepared for operations.

Completion of all duties and treatments is not obligatory by nine o'clock, but after that hour the number of student nurses decreases to about one nurse to six patients.

Abnormal conditions calling for readjustments of the schedule are under the control of the supervising nurse who, of course, accompanies physicians and surgeons on their rounds. In the meantime the interns have been as busily and quietly at work as the nurses. Occasionally a doctor arrives as early as 8:30 o'clock; nevertheless, he is seldom, if ever, delayed in seeing his patients and if a surgeon should wish to operate at 8 a.m., the supervisor sees that the patient is made ready. The majority of visits by the regular attending staff members are between 9 and 10 in the morning and there is no question about the prompt examination and treatment of their patients.

The administrators of the hospital and training school made the changes involved in this schedule after careful study primarily because disturbing the sick at so early an hour, with a long day ahead and yet dark at certain seasons, seemed inhuman.

Mother Louis, the superintendent, and Miss Moir, the director of nurses and principal of the training school, who have worked out the details, are eminently satisfied with the result.

Awaking ward patients in the earlier morning hours has been one of those routine practices in hospital life that has been considered impossible to break. It was even feared the dietary department would rebel, but this and all difficulties have been ironed out in the French Hospital.

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Maintenance, Operation and Equipment

A Positive, Inexpensive Method of Producing Sterile Goods

By THOMAS B. MAGATH, M.D.
Section on Clinical Pathology, The Mayo Clinic, Rochester, Minn.

THERE are few events in the practice of medicine so disappointing as to perform a difficult operation successfully and then to have the patient die because some material which entered the operative wound was contaminated with pathogenic bacteria. This hazard, although well known, still exists, often due to failure to appreciate some of the fundamental principles of sterilization.

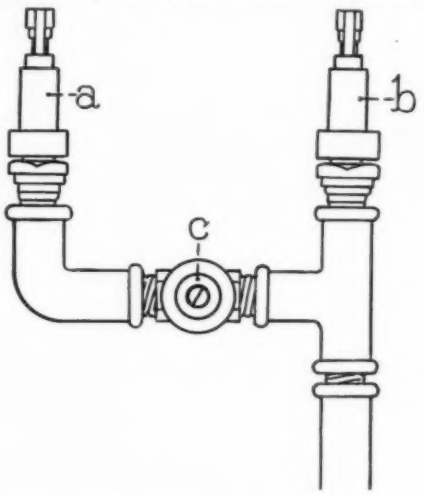
Not long ago Dandy reported the necessity of at least one hour's sterilization of cotton and linen goods before their use in the operating room.[1] This is good practice, but it is longer than necessary in some instances and not long enough in others. The crucial question is whether the temperature in the sterilizer (autoclave) has been maintained long enough to kill all bacteria, both vegetative and spore bearing. There is some difference in opinion as to the exact time required, but certainly twenty minutes at 121° C. (250° F.) is sufficient to allow a margin of safety.

The problem is to know that all the material in the sterilizer has been kept for this length of time at this temperature. Materials differ greatly in their properties; surgical cotton and cloth, both of which are filled with myriads of tiny air pockets, are the most difficult goods, next to cork, to sterilize. For that reason these articles should be sterilized the full length of time.

The Sterilization of Rubber Gloves

It is difficult to evacuate the cylinder of air when these goods are in the sterilizer and unless the instrument is equipped with some type of automatic air ejector, it is necessary to exhaust and blow out the sterilizer from three to six times before the temperature reaches the level which the pressure gauge indicates. Steam under pressure will not reach as high a temperature if air or if water of condensation is present, as will pure steam. The pressure gauge is not an accurate indication of the temperature of the sterilizer unless all the air is evacuated.

Without an expensive recording clock, it is impossible to ascertain that goods are sterilized unless an indicator is used with every batch of goods. Such indicators, to be of value, must be made so as to register the relation of time to temperature, and should have a lag of twenty minutes at 121° C. Anything less places the surgeon at a great disadvantage and is unfair to the patient. Indicators of this type are now on the market and should be required in every batch of goods that is sterilized. Actual observations in hospitals provided with the best equipment clearly indicate that every so often something goes wrong with the steam pressure, the vacuum, the packing of the sterilizer or the attendant in charge, and unsterile goods result, thus placing the surgeon in a position innocently to endanger the life of the patient.

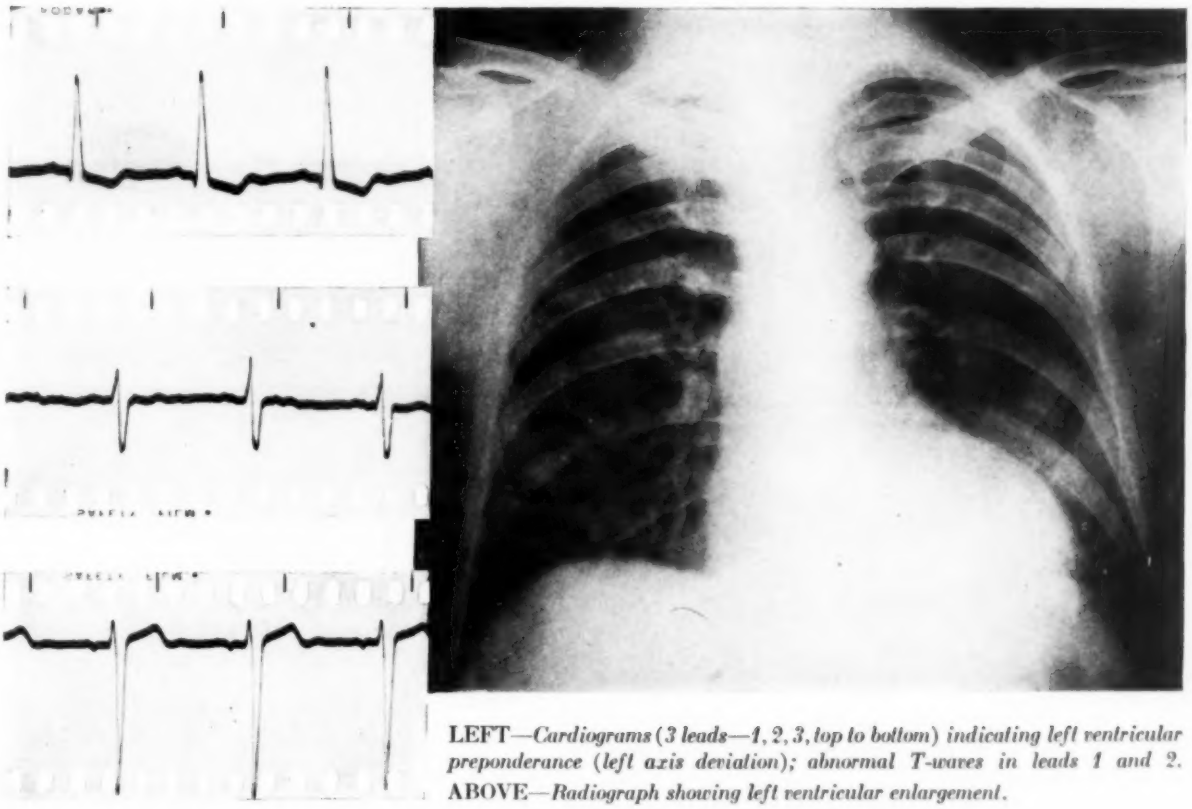


Simple method for reducing the pressure in a hospital sterilizer without changing the original pressure setting. (a) Safety valve set at 12 pounds; (b) regular safety valve, and (c) hand valve.

The sterilization of rubber gloves is another important event on the operative floor that often

[1] Dandy, W. E., The Importance of More Adequate Sterilization Processes in Hospitals, Bul. Am. Col. Surg., March, 1932.

THE RADIOGRAPH for Pathology



LEFT—*Cardiograms (3 leads—1, 2, 3, top to bottom) indicating left ventricular preponderance (left axis deviation); abnormal T-waves in leads 1 and 2.*
ABOVE—*Radiograph showing left ventricular enlargement.*

THE CARDIOGRAM for Function

THESE two examinations—the radiographic and the cardiographic—provide the comprehensive information that is necessary to arrive at a definite diagnosis in the study of heart conditions.

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For Electrocardiography Eastman Cardiographic Film and P. M. C. Bromide Paper No. 1 provide those photographic properties that assure accurate tracings . . . the exact recording of every impulse. The cardiograms have unusual contrast. Exposed areas are densely black. Unexposed areas remain absolutely clear. Eastman Kodak Company, *Medical Division*, Rochester, New York.

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Ultra-Speed X-ray Film, Cardiographic Film and Paper

is not thoroughly understood in spite of many published instructions. A survey of leading hospitals has disclosed the fact that no two hospitals use the same methods as to details. Three fundamental points must be kept in mind:

First, it will ruin rubber gloves to sterilize them for the same length of time and at the same temperature as are required for cotton goods; second, gloves which have smooth surfaces are more easily sterilized than cloth or cotton, and third, gloves should be practically sterile when they are placed in the sterilizer.

For these reasons a shorter period of time at a lower temperature should be used in sterilizing rubber gloves. This is not easy to accomplish with the usual equipment, but it can be done if the following simple changes are made in the sterilizer: (1) replace the nipple connecting the safety valve to the inner chamber with a "T"; (2) screw the safety valve to the vertical opening of the "T"; (3) screw a short nipple, followed by a hand valve and short nipple, into the side opening of the "T," and (4) by means of an elbow attach a safety valve set for twelve pounds.

To operate the machine for sterilizing gloves: (1) open the hand valve and run the sterilizer as usual; (2) after the inner chamber is thoroughly exhausted and filled with steam, and after the twelve-pound safety valve blows off, observe the time and sterilize for fifteen minutes, and (3) pull a five to ten-pound vacuum and open the sterilizer.

To operate the machine for all other sterilizing all that is necessary is to close the hand valve.

An indicator should be available to test sterilizing at this time-temperature relation. Gloves may be sterilized at a lower temperature provided the time is extended relatively.

The following procedure will be found satisfactory before the gloves are sterilized: (1) treat the gloves with 2 per cent disinfectant in distilled water for fifteen minutes; (2) rinse the gloves in running water; (3) test and repair the gloves; (4) boil the gloves for three to five minutes; (5) have the nurse scrub up and put on a sterile gown and spread a sterile sheet on the table (it is not necessary to wear rubber gloves); (6) dry the gloves with a sterile towel and powder them with sterile powder; (7) place the gloves in sterile muslin glove pockets; (8) wrap the gloves with sterile, double wrappers, and (9) sterilize the gloves at twelve pounds for fifteen minutes.

It is not easy to produce absolutely sterile and hence safe goods for the operating room, nor can this task be left to chance. It is possible to produce sterile goods, however, and it is an obligation on the operating room staff. While common sense is desirable, certain never to be broken rules are essential and an ample margin of safety must be allowed. A time-temperature indicator is the only economical method that is positive, provided an indicator is used which will indicate that a margin of safety has been used.

Every sterilizing room should have over its door the old adage: "Better be safe than sorry!"

A Novel Arrangement for Supplying Heat, Power and Water

An interesting arrangement for providing heat, power and water is in effect in the Jewish Consumptive Relief Sanatorium, Spivak, Colo. Heat, steam, power, light, water, fuel and labor in the engineer's department are considered as one account with appropriate subdivisions given for each item.

Natural gas purchased from a public utility is used in the boilers. High pressure steam is used for the engines, laundry, kitchen, sterilizers and refrigerators. Exhaust steam is used for hot water heating and feed water heating. In winter all excess exhaust steam is used in the heating system; in summer it is exhausted to the atmosphere.

Water is supplied from an artesian well situated close to the engine room. Excess water is purchased as needed from the municipal water company of Denver. Power and light are also purchased.

The institution has seventy separate buildings ranging from two-bed tents to a 200-bed hospital. At present it is caring for 185 patients and has 103 employees, practically all of whom live within the hospital grounds.

The monthly costs vary with the season. During June, 1933, they were as follows: gas, 3,344,000 cubic feet at 16⅔ cents per 1,000 cubic feet, $557; electric power, 7,500 kilowatts at 2.21 cents per kilowatt, $165; electric lighting, 3,160 kilowatts at 4.7 cents per kilowatt, $149; water purchased, 340,000 gallons at 17.7 cents per thousand, $59; the labor of boiler room attendants, $147.

The artesian well supplied 3,024,000 gallons of water during the month of June, which at the above rate would have cost considerably more than $500.

New Book for Medical Secretaries

The secretarial school graduate without medical training who contemplates becoming office assistant to a doctor, and the nurse without secretarial training who plans to assume similar duties will find invaluable information in Minnie Genevieve Morse's book, "The Medical Secretary," recently published by The Macmillan Company, New York City.

Considerable space is devoted to correct spelling and proper usage of medical terms—matters of paramount importance to the medical secretary. Other topics discussed in a simple understandable style are qualifications and personality of the medical secretary; medical correspondence, bills and reports; case records; medical indexing and filing; medical research, and preparation of medical manuscripts.

Large Hospital Finds Power Truck an Economical Investment

ELECTRICALLY driven trucks have long been used in industries where large quantities of materials must be handled. Mass production methods are little used in the hospital field, however, because individual attention has been the real aim of good hospital management.

In the larger institutions, nevertheless, many activities are really conducted on a mass basis. The handling of food, laundry and medical supplies in a large hospital is a typical mass production operation. Taking a hint from the industrial field, the management of the University Hospitals of Cleveland analyzed these various operations with the result that an electric truck is now used to do the bulk of heavy handling and hauling.

The University Hospitals consist of a number of detached units adjacently grouped. All units are connected by a system of underground tunnels and passages. Before installation of the electric truck all hauling between and within the various units was done by means of the usual type of hand truck. Collection and delivery of soiled linen to the laundry was a particularly arduous task under this method. Hand truck loads had to be pushed almost a quarter of a mile, one truck load per man. Part of the course was up a grade of 5 per cent.

The laundry is now handled in the same trucks which have been equipped with drawhooks. Trucks are coupled into a train of eleven cars maximum, with a total weight of some nine thousand pounds. The cars are towed by the power truck to the elevator in the basement of the laundry with a considerable saving of man power and about one-half the elapsed time heretofore required.

Is Used to Transport Food

In making laundry deliveries, the truck and its train must climb the 5 per cent grade previously mentioned and must pass through narrow doorways and snake around S curves. At one point it is necessary to make a turn of more than 90 degrees from a passageway 5½ feet wide into a passage 4¾ feet wide and then immediately ascend a steep grade. Even under these conditions the train successfully operates with four cars.

Considerable saving has also been effected in the delivery of prepared foods from the central kitchens to outlying units. Concentration of a considerable amount of food preparation is now practicable because quick deliveries can be made by means of the electric truck without detriment to the condition of the foods on arrival. Food trays have been equipped with drawhooks so that they can be handled as trailers behind the truck.

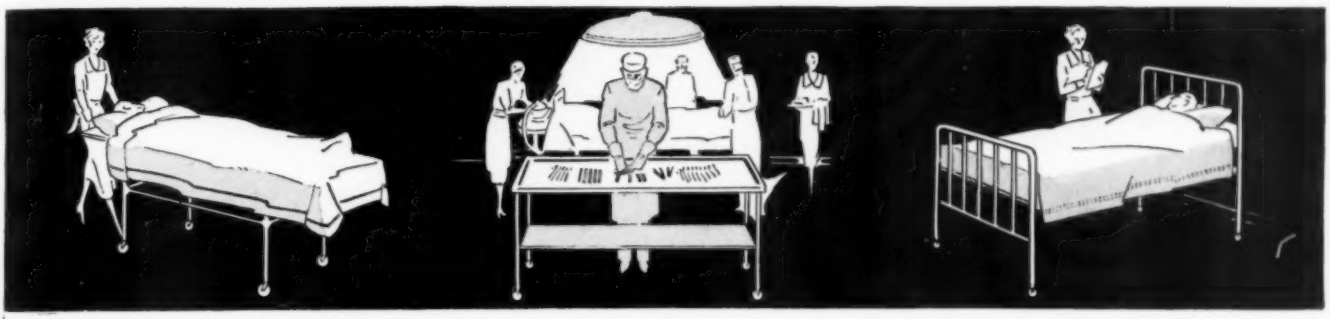
Hot food trays are equipped with electric heater elements with plug-in cords. The trucks are first warmed in the kitchen by means of heater elements. Then they are loaded with the hot prepared foods and immediately transported to their destination by the power truck. Upon arrival at the point of food distribution the heater cords are again plugged into convenient wall outlets and the foods are kept warm.

The power truck has lowered the cost of delivering food from the central kitchens.

This power truck is also used for transporting food and hospital supplies from the receiving room to storerooms, laboratories and pharmacy as well as for distributing many of the supplies from there to various points.

From the initial ten months' operation of this system, it is evident that the power truck and auxiliary equipment, which cost approximately $2,000, will, under normal operating conditions, considerably more than return the investment within the first year. Maintenance and electric power costs are negligible.

an entirely NEW LINE *of* HOSPITAL CASTERS



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Dietetics and Institutional Food Service

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

Bottled Beverages—Let Us Not Neglect Them

By LULU G. GRAVES
Consultant in Dietetics and Dietotherapy, New York City

MINERAL waters have long been widely acclaimed for their medicinal qualities. Watering places, the sources of natural carbonated waters, were known before Cleopatra developed her original method of dissolving a pearl in a glass of wine to make her own special brand. But watering places were luxuries available only to the wealthy and Cleopatra's product was even more rare.

It was not until Joseph Priestley impregnated water with carbon dioxide gas and a Philadelphia druggist, presumably Townsend Speakman, invented apparatus for doing this artificially and also for adding flavoring, that soft drinks were started on the road to becoming national beverages. The modern form of bottled carbonated beverage classed by the government as a food, is of comparatively recent development.

Water Regulates Body Heat

Mineral waters, carbonated waters and fruit juices are refreshing beverages and they are increasingly popular. They are of interest to hospitals for their psychologic as well as their dietetic value, since they afford a pleasing drink and everyone likes them in some form. Pure bottled beverages are primarily water flavored with a substance derived from fruit, seeds, or roots of plants. Some of these beverages are charged with carbonated gas. They may be refreshing or stimulating or both. Their contribution as a food is that of water supplemented by sugars, fruit acids and flavoring in varying quantities. The body needs water for the proper functioning of its organs. The quantity required depends largely upon the individual's dietary and other habits.

One of the major functions of water is regulation of bodily heat. Internal temperature must be kept at normal point regardless of the temperature of the surrounding atmosphere. The body loses heat by radiation when the air is cooler than the skin; it loses heat by evaporation when the air is drier than the skin. Carbonated beverages may help in this internal refrigeration system. First, such beverages are usually drunk cold and so reduce the temperature of the body; second, carbon dioxide stimulates the respiratory center and so increases the rate of breathing and the speed of evaporation. Many persons who will not drink a sufficient quantity of plain water will drink bottled mineral or carbonated water to meet their need.

Sugar Content Supplies Energy

These beverages are valuable in certain digestive disorders; they are contra-indicated in gastric disorders and hyperacidity, although their reaction in the body is alkaline. In the intestines the CO_2 seems to stimulate peristalsis and possibly aids elimination in other ways. Nausea following the use of anesthetics and inability to retain fluids because of vomiting may often be more successfully controlled by carbonated waters than by plain water.

The 7 to 17 per cent sugar content of carbonated beverages supplies an appreciable amount of energy. This is pure cane or beet sugar. Saccharine is rarely used today. Fruit acids, citric and tartaric, and other fruit esters contribute slightly to the nutritive value and add considerably to the flavor. These acids are widely distributed in Nature and the body is accustomed to dealing with them in foods. Ginger, herb extracts, fruit juices and oils are also used.

Federal regulation requires that the presence of artificial flavors and colors be indicated on the label even when these are used to stabilize or augment the natural flavors and colors. The label, "pure fruit juice," cannot be used with products

containing less than 33 per cent fruit juice. Artificial colors and preservatives are not necessarily dangerous. If the artificial product sells for as high a price as do those containing natural flavors, the buyer pays for something he does not get. When we buy a bottled beverage we may know what we are purchasing by reading the label, but buying a beverage in a glass at a soda fountain is quite another matter.

In order to prevent spoilage all components must be pure. Bottles must be sterile and the caps must be clean. CO_2 merely inhibits the growth of organisms and does not destroy them. CO_2 not only prolongs the keeping of the beverage, but it also gives a tang that adds pungency to the drink.

Mineral Waters Add Zest to Fruit Juices

Waters issuing from springs in certain sections of the country have sufficiently high mineral content to make them important in the prevention of specific diseases. For example, spas in a section of the country where the water contains an abundance of iron make the most of this fact. Likewise, lack of iodine in water is definitely associated with the prevalence of goiter. But the medicinal properties claimed for spring waters cannot be wholly attributed to their mineral content. No small part of their therapeutic value is due to liberal consumption of water. This is equally true of bottled mineral waters. They are thirst quenchers with a distinctive flavor, usually pleasant when taken plain, and they add zest to mixtures of fruit juices and other concoctions.

Bottled unfermented fruit juices have become standard supplies just as have canned goods. They are preserved at a temperature that destroys yeasts and molds. They are hermetically sealed, and will not spoil so long as they remain sealed. The nutritive value of these juices varies with their concentration. In general, they have considerable amounts of easily assimilated sugars, organic acids and vitamin C, with small amounts of other vitamins in some cases. They yield an alkaline ash in the body, as do the fruits themselves, they are mild diuretics and some have slight laxative properties for some people.

Besides being served as beverages on the luncheon tray or between meals, these juices are commonly used in salads and desserts, particularly custards, whipped cream and gelatine desserts and gelatine salads.

Orange, lemon, preserved ginger and mint are favorite flavors for blending with each other or with carbonated beverages. Limes are deserving of wider use than they have at present. Their price is higher but their flavor is stronger and fewer are required. Grape and pineapple are popular sweet juices because they are refreshing and nutritious, and they play an important part in fluid and soft diets. Loganberry, a little less sweet, is adapted to the same use and is frequently preferred by patients with high temperatures and by others who object to a drink that is too sweet. Bottled beverages may be substituted for all or for part of the water commonly used in many salads and desserts. The faintly acid taste and the CO_2 add piquancy to mousse and similar whipped cream desserts as well as to gelatines. Delicious ices and sherbets also are made with bottled beverages.

Children are especially fond of the following combinations: (1) a milk shake made with equal parts of milk and beverage; (2) an eggnog made in the usual way, combined with orange or strawberry carbonated beverage and well beaten or shaken in a shaker; (3) a simple ice cream soda made by placing a tablespoonful of vanilla ice cream in a half glass of ginger ale, stirring with a fork until well blended, and filling the glass with ginger ale. This ice cream soda, comparatively inexpensive, might solve the problem of a holiday treat that is different.

These drinks and desserts are best when thoroughly chilled. This does not imply that they are summer foods exclusively. All of them are enjoyable in any season. Their function on the menu may be to stimulate appetite or to bolster morale rather than to nourish. This point in diet therapy is not to be ignored and frequently it should receive first attention.

How Student Nurses Spend Their Day in Ten Hospitals

According to Blanche Pfefferkorn, National League of Nursing Education, student nurses spend more than two-thirds of their day doing maid and orderly work in ten Eastern hospitals studied. Miss Pfefferkorn states that the one absolute criterion in determining assignment of duties is the welfare of the patient, and if an excess amount of time is devoted to housekeeping duties, the patient and the nurse's training tend to be neglected.

"Robert E. Neff, administrator, University of Iowa Hospital, Iowa City, Iowa, suggests that in substituting a graduate for a student service all first year students should be replaced by maids," states Miss Pfefferkorn, who adds: "On the basis of what some student nurses appear to be doing this suggestion would seem logical. . . . One hospital estimates that two graduates and a maid could carry all the nursing service given by ten students. This would seem to imply that this hospital recognized that one-third of the nursing time of its students was utilized for the work of maids." Although it is true that the hospital apparently reduces operating costs by assigning such tasks to student nurses it does not follow that it "profits" thereby.

Good Will—and Food—Are Dispensed by the Dietary Department

By JOSEPHINE SUTFIN
Dietitian, Essex County Hospital, Cedar Grove, N. J.

BECAUSE the dietary department is the core of good will in the hospital, it receives a great deal of attention. Breakfast, dinner and supper are bright spots in the patient's day. Good wholesome food certainly helps to keep employees in good humor. Food is one of the largest items of hospital expense. A great amount of time is devoted to this subject in the accounting department. The directress of nurses is particularly anxious that student nurses shall be properly nourished. The superintendent of the hospital is very anxious to keep food complaints down to the minimum.

The Ideal Employee

Every hospital employee should be instructed to some extent concerning the activities of the dietary department so that he may appreciate the vital part the department plays in the patient's return to health. The dietary department of the hospital has developed rapidly in the past fifteen years and the fact that food is an important factor in hastening the recovery of the patient is now widely recognized.

Great care should be exercised in selecting employees who are concerned in any way with food. Suppose that the dietitian in charge of the food department approaches the storeroom and receiving department. She finds the storekeeper refusing a shipment of canned corn which is not according to specifications. She listens intently and quietly until all is settled and then she commends the storekeeper briefly but definitely.

Here is the ideal employee. First, he knows his business and he is honest. Second, responsibility has been placed on his shoulders and he assumes it seriously. Third, he discharges his duties to his own credit and to the best interests of his employer, the institution. He should be commended, for any human being has more or less of an ego and that ego needs bolstering. Administrators and department heads are too often careless of this fact.

How is such an ideal employee found? First, definite standards for good health, appearance, behavior and intelligence must be maintained. The cook cannot indulge in periodic spells of inebriation. The kitchen man or bus boy cannot be the wandering type. The dining room maid must be attractive and not flirtatious.

The hospital, in demanding sensible standards, should proudly and sensibly say, "We are offering you a minimum wage. If you stay with us and your behavior and work are satisfactory your wage will be raised accordingly. We offer a nice room for you to live in. You will not be required to share this room. Its neatness depends upon you; we shall take care of the housekeeping. If you are to live outside, the cares of your outside life are to be left outside. Your food will be wholesome and served attractively. Your working surroundings are the best we can provide so that you may be content. The equipment you use is of the best and is fitted to the needs of this institution. We expect you to use it intelligently after you have been carefully instructed. We expect you to work eight hours in the day but you must understand that this is not a factory; the return to health of many patients depends upon your good share of service. This work is service and we want you to like it or we do not want you to stay."

The dietitian in charge of the dietary department should hire the employees who are to work there, but always with the approval of the superintendent or the director.

Making Changes in Personnel

To avoid arguments, to prevent favoritism, to ensure a well conducted department, every employee should have a clear understanding of his or her duties under normal conditions as well as in emergencies. Such an understanding develops self-reliance and creates an opportunity for the development of constructive ideas. This definite placement of responsibility is vital to the soundness of organization.

Especially in institutions that have been established a long time, we find periods of growth and improvement. These periods are marked by new building or by the rearrangement of rooms and departments. Along with physical changes and

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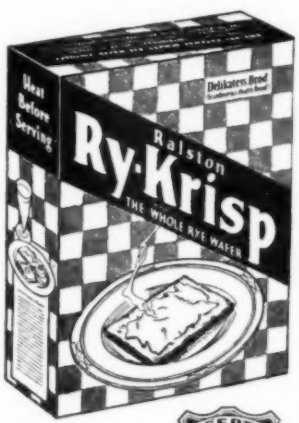

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adjustments, the personnel is bound to be changed or adjusted. Great harm can result at such times unless the situation is tactfully handled. In some cases the harm is of short duration; in other cases it is of long duration and of a radiating quality which may place a lingering stigma over the institution.

In making adjustments or alterations in the hospital it is always the aim of administrators and department heads to plan not only for present needs but for future growth.

In our enthusiasm, eagerness and close application of mind and energy to our work, particularly during a period of reorganization and adjustment, we must not overlook the fact that there are employees who have been working steadily and pridefully for a number of years. In some cases the usefulness of such employees is gradually diminishing, while the usefulness of others seems to develop.

The Dietitian's Responsibility Is Great

It is not the long term employee who develops with his work that is a problem in the older institution. It is, rather, the employee whose usefulness is gradually decreasing. We have a responsibility to that one for his faithfulness during many years of labor. Perhaps the hospital is his home and all his friends are there. At least, we must face the fact that he has been in the hospital's employ so long that to make adjustment in a position elsewhere would be a social problem.

In reorganizing older institutions we must remember that the human element is the keynote toward the success of the whole project. A fund should be available to care for employees whose diminishing usefulness is due to advancing years. If the usefulness of an employee is diminishing because of mental laziness, he can be made to feel that his responsibility has been increased. If the appeal to pride fails, then more drastic measures may be taken.

The dietitian's responsibility is a great one. She is the link that holds the dietary department close to all other departments. She must provide food to meet many therapeutic needs, to promote health and to maintain health. A good dietitian should have, first of all, good health. Then she needs stamina, education, training, a sympathetic understanding of human nature. She should be ambitious and endowed with a sense of humor and good common sense. Her morals will be all right if she has common sense.

Her responsibilities are summed up in one statement: She is in charge of the dietary department. She should be in charge absolutely and definitely. She in turn is responsible to the director or superintendent of the hospital. The complaint is often heard, "We did give the dietitian full charge and she didn't know her job. The results were expensive in more ways than one and we had to make other arrangements. We're about done with dietitians."

I shall not attempt to defend such dietitians. Obviously they did not possess the qualifications of good dietitians.

It is an expensive proposition to take a recent home economics graduate into the hospital as a student dietitian. She has to be watched and the only one to watch her is the head dietitian who already has so much to do that she hasn't any time to devote to the training of this young woman. Somewhere along the line something will slip simply because this young student dietitian is not ready to assume responsibility. Or perhaps she is not capable. After her period of training, she may, with a smattering of information, take charge of a food department in another institution. It is not surprising, then, that heads of institutions become dubious about dietitians.

The placement bureau of the American Dietetic Association specializes in putting hospitals in touch with capable dietitians—young women fitted to the jobs.

Realizing their responsibilities to the hospital and kindred institutions, the dietitians of New Jersey recently organized the New Jersey Dietetic Association with high standards and qualifications for membership. Although only a few months old, it has definitely identified itself with the American Dietetic Association and is prepared and eager to serve the hospital field.[1]

Unit Filing System Proves Valuable

The New York Post-Graduate Medical School and Hospital, New York City, has found that the unit system of filing records produces good results. Under this system, which was installed in January, 1931, all the records of a patient are bound together, including the current hospital record, the records of any previous hospital admissions, the clinic record (if the patient has been treated in the clinic) and any correspondence pertaining to the case. The system has proved of great benefit to the doctor who is treating the patient and to the doctor who is using the records for research. It also often saves unnecessary duplication of x-ray and laboratory work.

The 9,665 patients discharged during the year 1932 were treated for 15,089 conditions. These conditions have been indexed according to the new standard classified nomenclature of disease, both topographically and etiologically. This system of indexing diagnoses is valuable because of the ease with which records can be made available to doctors who wish to study certain types of diseases.

[1]Read at the meeting of the New Jersey Hospital Association, Asbury Park, May 19-20.

September Dinner Menus for the General Hospital Patient*

By ANNA E. BOLLER

Day	Appetizer or Soup	Meat or Substitute	Potato or Substitute	Vegetable	Salad	Dessert
1.	Tomato Juice, Chilled	Broiled White Fish	Potatoes Hashed in Cream	Spinach With Lemon	Waldorf	Brown Betty With Cream
2.	Mushroom Bisque	Meat Loaf, Spanish Sauce	Baked Potatoes	Buttered Brussels Sprouts	Asparagus	Pineapple Upside-Down Cake
3.	Bouillon With Croutons	Chicken, Southern Style	Mashed Potatoes	Fresh Lima Beans	Shredded Lettuce, Russian Dressing	Minted Fruit Cup
4.	Cream of Asparagus Soup	Veal Birds	Browned Potatoes	Escalloped Cabbage	Grapefruit and Tomato	Strawberry Ice Cream, Petit Fours
5.	Celery Bisque	Roast Beef Hash	Baked Tomato	Escalloped Corn	Ginger Ale and Pear	Cottage Pudding, Lemon Sauce
6.	Iced Tomato Juice	Ham Loaf, Horse-radish Sauce	Creamed Potatoes	Baked Squash	Jellied Fruit	Milk Sherbet
7.	Cream of Celery Soup	Fillet of Haddock, Tartar Sauce	Stuffed Baked Potatoes	Buttered Beets	Tomato and Cucumber	Peach Shortcake
8.	Minted Grapefruit Cocktail	Rice Croquettes, Cheese Sauce		Broiled Tomatoes	Stuffed Prune	Date Pudding
9.	Honeydew Melon Cocktail	Fricassee of Veal	Buttered Noodles	Glazed Carrots	Head Lettuce, Russian Dressing	Gingerbread With Whipped Cream
10.	Minted Pineapple Cocktail	Roast Shoulder of Lamb	Browned Potato	Harvard Beets	Mixed Green	Rice Bavarian With Peaches
11.	Chicken Broth	Baked Ham	Escalloped Potatoes	Sautéd Bananas	Celery and Olive	Apple Betty, Hard Sauce
12.	Two Tone Cocktail	Broiled Lamb Chops	Creamed Potatoes	Buttered Asparagus	Pineapple and Tomato	Chilled Custard With Peaches
13.	Fresh Fruit Cocktail	Roast Chicken, Sage Dressing	Sweet Potatoes	Buttered Broccoli	Lettuce Hearts, French Dressing	Pineapple Bavarian Cream
14.	Cream of Tomato Soup	Broiled Steak, Sautéd Mushrooms	Parsley Buttered Potatoes	Baked Squash	Frozen Fruit	Angel Food Cake
15.	Tomato Bouillon	Lake Trout	Escalloped Potatoes	Buttered Spinach	Pineapple and Carrot in Lemon Aspic	Orange Ice
16.	Fresh Vegetable Soup	Liver and Bacon	Mashed Potatoes	French Fried Onions	Mixed Vegetable	Apple Cobbler
17.	Fruit Cocktail	Roast Beef	Browned Potatoes	Creamed Cabbage	Grapefruit and Orange	Chocolate Ice Cream
18.	Chilled Pineapple Juice	Roast Lamb	Browned Potatoes	Diced Beets	Apple and Celery	Frozen Custard
19.	Cream of Spinach Soup	Roast Shoulder of Veal	Hashed Brown Potatoes	Buttered Cauliflower	Sliced Tomato	Cantaloupe
20.	Spiced Grape Juice	Swiss Steak, Vegetable Gravy	Baked Potatoes	Buttered String Beans	Pear and Cheese	Floating Island
21.	Seafood Cocktail	Baked Ham	Glazed Sweet Potatoes	Escalloped Tomatoes	Grapefruit	Chocolate Blanc-mange
22.	Chilled Orange Juice	Broiled Mackerel	Parsley Buttered Potatoes	Escalloped Corn	Celery and Olives	Prune Whip
23.	Cream of Sauerkraut Soup	Broiled Lamb Chops	Au Gratin Potatoes	Brussels Sprouts	Jellied Vegetable	Baked Pears
24.	Vegetable Chowder	Chicken Fricassee With Mushrooms	Mashed Potatoes	Buttered String Beans	Frozen Fruit	Caramel Sundae
25.	Ginger Ale Fruit Cup	Escalloped Ham and Potatoes		Broccoli	Combination	Baked Apples With Cream
26.	Cream of Spinach Soup	Liver and Bacon	Mashed Potatoes	Grilled Tomato	Peach and Cottage Cheese	Washington Cream Cake
27.	Cream of Corn Soup	Fried Chicken	Baked Stuffed Potatoes	Cauliflower, Hollandaise	Mixed Fruit	Charlotte Russe
28.	Grapefruit Supreme	Breaded Veal Chops	Creamed Potatoes	Wax Beans	Tomato Aspic	Cottage Pudding
29.	Melon Cup	Salmon Soufflé, Egg Sauce	Au Gratin Potatoes	Buttered Peas	Cole Slaw	Mocha Ice Cream, Lady Fingers
30.	Grapefruit Juice	Roast Duck, Sage Dressing	Sweet Potatoes With Marshmallows	Buttered Broccoli	Combination	Baked Custard,

*Recipes for any of the above dishes will be supplied upon request.

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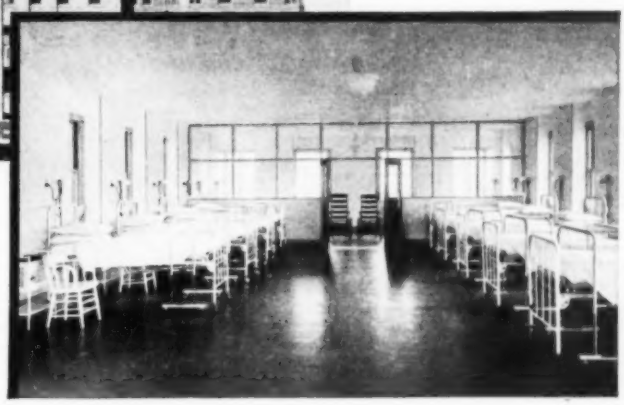

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Lima Hospital, Lima, Ohio	50,000 sq. ft.
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NEWS OF THE MONTH

Nonprofit Hospitals Are Not Affected by Code Requirements, NRA Counsel Rules

Hospitals "not engaged in carrying on a trade or industry" are not required to formulate a code under the National Industrial Recovery Act. The effect on voluntary hospitals of the new processing tax on cotton and wheat has not yet been fully settled but it is believed that hospitals may obtain refunds of such taxes paid on supplies used for charitable purposes.

The first of these two aspects of the President's recovery program was discussed with the NRA by a committee representing the American, Protestant and Catholic hospital associations which convened in Washington, D. C., on August 16 and 17. The committee met first to formulate a policy which was then presented to General T. S. Hammond, executive director of NRA. The committee found that application of the "blanket code" would, in the average hospital, add approximately $100 to the annual cost per occupied bed.

After consultation with the hospital representatives, General Hammond referred the legal aspects of the question to Donald R. Richberg, general counsel of the NRA, who prepared the following interpretation of the code:

Nonprofit Hospitals Not Affected

"Hospitals, not engaged in carrying on a trade or industry, do not come within the purview of the National Industrial Recovery Act so as to come under the ordinary requirement of a code of fair competition. There is nothing to prevent any employer of labor outside of trades and industries, any professional man or organization, or any nonprofit organization from signing the President's Reemployment Agreement and conforming to its provisions. This does not mean, however, that they are under any compulsion to do so other than that resulting from a desire to cooperate where appropriate, and so far as possible, with a general program of reemployment at shorter hours and higher wages. To the extent that labor is employed in occupations comparable with those engaged in trade or industry it is, of course, desirable that similar conditions should prevail."

The committee which obtained this interpretation was composed of Dr. Nathaniel W. Faxon, president-elect, American Hospital Association, Rochester, N. Y.; Rev. Alphonse Schwitalla, president, Catholic Hospital Association, St. Louis; Rev. Thomas A. Hyde, president, Protestant Hospital Association, Jersey City, N. J.; R. P. Borden, Fall River, Mass.; Dr. S. S. Goldwater, New York City; A. J. Lomas, Baltimore; Dr. Frederic A. Washburn, Boston; Rev. Maurice F. Griffin, Cleveland; John H. Olsen, Prince Bay, N. Y.; Howard E. Bishop, Sayre, Pa.; Jessie J. Turnbull, Pittsburgh; Charles S. Pitcher, Philadelphia; Ernest Schulz, Newark, N. J.; Mr. Mountason, Washington, D. C.; M. R. Kneifl, St. Louis, and Dr. Bert W. Caldwell, Chicago. Doctor Faxon, Rev. Schwitalla and Doctor Hyde made the presentation to General Hammond.

Refund Method Undecided

The methods by which charitable hospitals may obtain refunds of processing taxes paid on cotton and wheat products are still undecided. These taxes are in two parts: first, a tax levied but once on all stocks of goods made wholly or in part from cotton or wheat which were on hand on July 1 and which were not sold or used before August 1 and, second, a tax paid by the processor on all goods processed after July 1.

In a letter to the American Hospital Association, D. S. Bliss, acting deputy commissioner of the Treasury Department in Washington, points out that the character of the use rather than the character of the institution is the determining factor in passing upon applications for a refund. "Even though the product be delivered to a charitable organization, there is no right to reufnd unless the . . . use of the product delivered is exclusively in the relief of the poor and indigent. Thus the delivery of a product to a state institution, or a hospital, does not itself give rise to a claim for refund, but if a product is delivered to the state institution, or the hospital, to be distributed or used by it exclusively in the relief of the poor and indigent, such delivery is ground for a refund."

The American Hospital Association is now preparing to suggest to the federal government appropriate methods by which hospitals may determine what proportion of their purchases are used exclusively in the relief of the indigent. It is understood that refunds will not be granted unless the goods in question have been purchased directly from the manufacturer. Forms for filing claims for refund, P. T. Form 24, may be obtained from local collectors of internal revenue. Full directions will be available later.

Prices Being Readjusted

Firms manufacturing gauze and other hospital supplies which use cotton are readjusting their prices to recompense them for new taxes. On a coarse grade of gauze, one firm has recently raised the price from $1.90 per 100 yards to $2.95 per 100 yards. About $0.22 of this increase is due to the processing tax of 4.2 cents a pound on cotton, another $0.22 is due to the increased costs arising from shorter hours and higher wages for laborers, and the balance is mainly a result of higher market prices for cotton and other supplies. This firm reports that it adds the cost of the processing tax at the end of its operations rather than at the beginning. Thus the tax is not multiplied several times. It is reported, however, that some firms add the tax at the beginning and thus pyramid its effect.

Dr. Goldwater Will Advise Russia on Hospitals

Dr. S. S. Goldwater, hospital consultant, New York City, has been retained by the Russian government to collaborate with government engineers and clinicians in the study of hospital plans. Prof. N. T. Krasnogorski, head of the Pediatric Institute, Leningrad, and Fedor Sadovski, head of the government building board, have been directed to proceed to New York City for this purpose in September. Conferences in Leningrad and Moscow will be held following the meeting in New York City.

NEWS OF THE MONTH

N. Y. Department of Insurance Rules Group Hospitalization Is "Insurance"

Is "group hospitalization" insurance under the terms of the state laws governing the insurance business? According to the Council on Community Relations of the American Hospital Association "insurance commissioners in more than a dozen states have ruled that hospital service rendered to subscribers in an annual payment plan is not insurance."

When, however, the United Hospital Fund of New York presented a plan to the state superintendent of insurance it was held that this was insurance, and it was suggested that the insurance law should be amended to cover this new need. A committee headed by Dr. S. S. Goldwater, New York City, is now preparing such legislation.

The written opinion prepared by Howard C. Spencer, counsel of the New York department of insurance, is of unusual interest. The gist of this opinion is as follows:

"Those in the department of insurance most conversant with the matter have felt that there was no method whereby the proposed plan could be satisfactorily consummated under the insurance laws as they now exist. The risk is most closely allied to accident and health coverage and the standard statutory provisions governing accident and health policies are unusually detailed and ill-suited to such a risk. Further, the organization requirements under the present law are not particularly adaptable to such a scheme.

State Must Have Control

"I have been unable to discover any method of properly differentiating the proposal of the Associated Hospital Service of New York from the rejected scheme of the U. S. Travelers Hospitalization Corporation.

"To begin with it is readily apparent that some check must be exercised by the state upon the activities of those who will seek in different degree to use this new twist of an old idea for the exploitation of the public. . . In the second place, at the present time the only adequate statutory control over these matters is the law prohibiting the doing of an insurance business without compliance with the insurance laws of the state. It follows that nothing should be done which will destroy the effectiveness of this law.

"How may the present project be distinguished from the U. S. Travelers Hospitalization Corporation?

"In the first place it is suggested that the contracts of the Associated Hospital Service of New York would be service contracts and not contracts of insurance. I think the distinction is largely illusory.

A Definition of Insurance

"What is insurance? . . . Whenever there are contributions to a central fund of a great number of relatively small amounts for the purpose of bearing relatively large losses which are expected to occur to only a limited number of contributors, there is in my opinion a risk distributing scheme which is insurance no matter what it may be called and no matter what form the proposed indemnification may take.

"It is true that this definition includes certain matters which the state has never undertaken to regulate. . . For example, a lawyer may undertake for a small annual retainer to take care of all of the business which may arise involving his clients. Or, a doctor may agree to furnish his services upon a similar basis. These examples of insurance have been exempted from the usual state supervision upon the alleged basis that they constituted contracts of service rather than contracts of insurance. In my opinion, however, the true distinction lies in the fact that where the performance upon the part of the insurer consists largely of physical or mental labor upon the part of himself or his immediate associates, the likelihood of nonperformance is relatively slight and in any event is of minor consequence to the public as a whole. Furthermore, such situations do not readily lend themselves to effective supervision. When, however, one of these small entrepreneurs enlarges his operations by hiring others to perform services for him upon a large scale although the character of the service may not change in the least the public interest becomes recognized and it is said that it is no longer a contract of service but a contract of insurance.

"It has also been pointed out that where the arrangements do not contemplate any profit to promoters the likelihood of objectionable features is considerably minimized. No doubt this is true. But the motives of the promoters and the manner of distribution of any surplus are of little materiality in the determination of whether a plan constitutes the doing of insurance.

"Supervision is not wholly a matter of detecting wrongdoing and insurance supervision particularly is not based upon the theory that all who are engaged in the business are scoundrels. The success of an insurance plan depends not alone upon the integrity of the promotors. It depends in addition upon technical experience, expertness of management and investment, strong financial backing, and freedom from certain types of competition. It may well be that those sponsoring the present plan are willing and able to agree to absorb any deficiency in expected income. This would not alter the fact that this is an insurance operation. Permission to one group would encourage other applications, perhaps only slightly less meritorious."

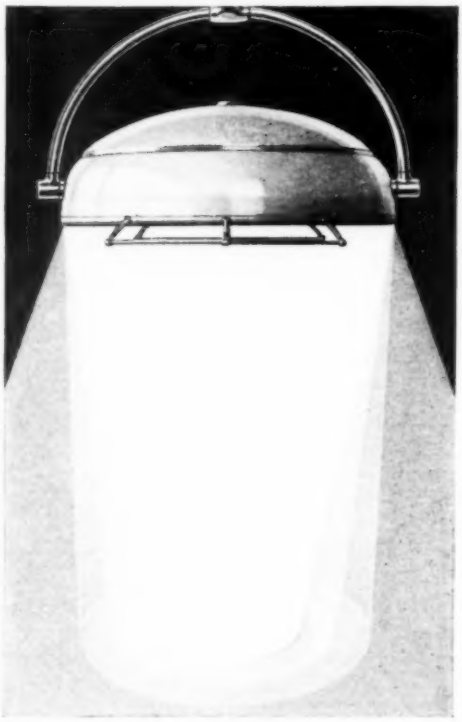
Free Service Mounts in Joint Diseases Hospital

Seventy-five per cent of the service rendered by the Hospital for Joint Diseases, New York City, during the past year was in its wards where 3,110 patients were cared for, according to the annual report of that institution. Nearly half of this service was free, and only 400 of the patients paid the nominal charge of $3 a day.

In the main hospital, 47.5 per cent of the ward service was free, or 39,848 hospital days of free service out of a total of 83,790 days. In the country branch, 9,506 free days out of 23,389 represented 40.6 per cent free service. In the out-patient department 221,132 visits were made, 66,514 being free.

Expenditures in both the hospital's main building and its country branch, at Far Rockaway, were lowered appreciably, the average amount to operate both divisions being reduced from $1,966.56 a day in 1931 to $1,735.10 last year.

SHARP, JAGGED, TEARING EDGES OF LIGHT



At our Booth No. 240 at the A. H. A. Convention, we will be glad to demonstrate the soft edged light-field and other features of American Surgical Lamps.

IN and out of the operative field, from intense light to comparative shadow, the eyes must travel—in and out, in and out, again and again during every major operation.

Whether or not the surgeon is concious of it, every time his eyes pass the light-field border, they must adjust themselves to new light conditions. Sudden changes of light intensity, sharp, jagged, tearing edges of light, put unnecessary tax on nerves and muscles, induce fatigue.

Only American Operating Lights, with their soft-edged light-field, are so completely engineered for the surgeon that they provide an easy path in and out of the light-field. Elimination of contrast glare is just one of the reasons why American Surgical Lamps provide greater comfort, conserve energy and make possible greater accuracy.

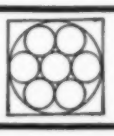
American Surgical Lamps are available in Major units, Minor units, "O B", Spotlight and Emergency units. We shall appreciate an opportunity to give you the whole story of these remarkable lamps.

AMERICAN SURGICAL LAMP COMPANY
104 E. MASON STREET MILWAUKEE, WIS.

COOL

DAYLIGHT
COLOR CORRECTION
AMERICAN LIGHT

INCISION
ILLUMINATION



DEPENDABILITY

NEWS OF THE MONTH

Institute Registration Exceeds Expectations

Paid registrations for the American Hospital Association's Institute for Hospital Administrators, to be held in Chicago from September 18 to October 6, total 138 as this issue goes to press. Additional applications are arriving daily. The officers of the institute, who originally expected an attendance of about fifty, have extended their quota to 150.

One section of a new dormitory at the University of Chicago has been set aside exclusively for the use of institute students. This section, which has never been occupied, is fully equipped and has a dining room, lecture rooms and conference rooms. Accommodations are available for men and women, for Negroes as well as white persons and for men accompanied by their wives. The cost for lodging is $1 per person per day.

Occupational Therapists Announce Meeting Plans

The American Occupational Therapy Association will meet in Milwaukee, September 11 to 13, for its seventeenth annual meeting. The board of management will meet on the evening of the eleventh, and the program will open on Tuesday morning, September 12, with Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, president of the association, in the chair.

Two subjects of interest that will be discussed Tuesday morning are "The Importance of Occupational Therapy in Institutional Management," by William J. Ellis, commissioner, department of institutions and agencies for New Jersey, and "Development of Treatment by Occupation in Queen's Hospital, Honolulu," by Mrs. H. M. Dowsett.

The chairmen of the standing committees will deliver their reports on Tuesday morning, and the election of officers will take place.

On Tuesday afternoon there will be an orthopedic symposium, with Dr. Frederick J. Gaenslen, Milwaukee, presiding. General discussion on the following subjects will follow: "shoulder, girdle and back," "elbow and forearm," "wrist and fingers" and "hip, knee and ankle."

The annual banquet will be held on Tuesday evening.

On Wednesday morning there will be a session at Muirdale Sanatorium, Wauwatosa, Wis., with Dr. Glenford L. Bellis, superintendent, serving as chairman. The Wednesday afternoon session will be held at the Asylum for Chronic Insane, with Dr. Paul H. Rupp, superintendent of the institution, serving as chairman. "Occupational Therapy With Acute Mental Cases" and "Occupational Therapy With Chronic Mental Cases" will constitute the two major topics of discussion at the afternoon session.

Nurses Work Eight Hours— No Change in Rate of Pay

The Missouri Pacific Hospital, St. Louis, has announced that it is putting all nurses on an eight-hour basis with no change in present rates of pay. A force of twenty-three graduate nurses will be increased to twenty-six to provide for the shorter hours. H. J. Mohler, president, Missouri Pacific Hospital Association commented on the change as follows:

"While it is generally understood that the National Recovery Act will not cover professionals, which no doubt includes nurses, and it would not therefore, under the act, be required that hospitals reduce their hours, we feel that graduate nurses for many years have been required to work unusually long hours. . . . We believe that all hospitals should at this time do what they can to assist in reducing hours for graduate nurses and comply with the request of President Roosevelt to create new positions, thereby placing more graduate nurses to work without any loss of income in instances where their working hours are reduced."

Medical Care Problems Discussed at Annual Great Lakes Institute

The interest of social work executives in the provision of medical care was given clear recognition at the Great Lakes Institute, held recently at College Camp, Wis. One of the four study sections included in the discussions of the conference was on the subject of "medical care."

After a week of discussion, this section adopted a report commending health insurance, the use of tax funds to supplement individual resources when necessary, the coordination on a community basis of the personnel and facilities for medical care, and a wider participation by social workers in solving community health problems.

Individual purchase of and payment for medical services has maintained an economic barrier between the need and the receipt of medical services by individuals, according to the report adopted by the section. The extension of both group purchase and taxation is looked to as an aid in solving the difficulties in individual purchase.

"Medical services might well be more generally provided by medical practitioners (physicians, dentists, nurses, technicians) acting in groups and in conjunction with medical institutions, in such ways as to maintain high standards and to preserve all important relationships between practitioners and patients," the report avers.

Social workers may assist in improving the conditions of individual and public health, according to the report, through studying the facts about the distribution of medical services in their communities, influencing public opinion, stimulating action, pointing out the necessity of considering social attitudes as well as technical professional functions, educating the public to the value of good medical care, and coordinating their own specialized functions with the work of medical practitioners and institutions.

The section on medical care was headed by C. Rufus Rorem, associate director for medical services, Julius Rosenwald Fund, Chicago. Alexander Ropchan, secretary of the health division, Chicago Council of Social Agencies, acted as secretary.

NEWS OF THE MONTH

New California Law Requires State License for Clinics and Dispensaries

The California legislature at its recent session passed a bill which defines, classifies and regulates clinics and dispensaries. Under this law, all clinics in the state, with a few exceptions, must apply for and obtain a license from the state board of public health. The exceptions are clinics maintained by the United States government, those operated by employers without profit for the sole benefit of their employees and nonprofit research clinics.

The clinics are divided into five classes, as follows: (1) charitable, (2) teaching and research, (3) employer's, (4) private pay and (5) governmental. Charitable clinics are permitted to make nominal charges to patients if approved by the director of public health. Private pay clinics must be conducted and operated only by persons duly licensed to practice medicine, surgery, dentistry, osteopathy, chiropractic or drugless healing.

Probably the most important provisions of the act are (1) those which lay down the basis on which clinics shall be licensed and (2) those which authorize the state board of public health to make reasonable rules and regulations governing the maintenance, conduct and operation of clinics to assure adequate facilities and qualified personnel, to determine the desirability of public financial support, to prevent overlapping and duplication, and to limit facilities to those really needed by the community.

In granting licenses to clinics the state health department is directed to determine whether there is need for such a clinic and whether its establishment or continued operation is for the benefit of the public health. The director of public health is authorized to inspect the premises occupied by clinics and examine all matters in relation thereto. He is also directed to make an annual report on clinics in the state.

The annual license fee is $5 to $25.

Ohio Hospitals Protected in Auto Accident Cases

Through the efforts of the Ohio Hospital Association an act was passed at the recent session of the Ohio legislature providing a fund for the reimbursement of hospitals for care given to indigent persons injured in motor vehicle accidents. From every auto license fee $0.19 is set aside for use of the state registrar of motor vehicles to meet the claims of hospitals.

In order to have a claim the hospital must first exhaust all other reasonable avenues for the collection of its bill. To prove indigency, the person concerned if living must make an affidavit of indigency which must be supported by a statement of a public official or social worker. Hospitals are reimbursed according to their per diem cost as determined for purposes of workmen's compensation by the industrial accident commission. If a hospital is paid by the state and later is able to collect from the patient it must do so and reimburse the state.

Hospitals in Ohio have been asked to keep careful account of all automobile accident cases so that the state association may be able to present accurate figures to the legislature in the event that the present law is found ineffective in its operation.

New Jersey Hospitals Receive Relief Funds

Through the state emergency relief administration, nongovernmental hospitals in New Jersey are being reimbursed in part for the cost of caring for indigent patients. The rates which the administration pays, however, in no sense represent the true cost of service.

"It is the belief of the New Jersey administration," according to D. H. MacNeil of the department of standards and research, "that hospitalization should be supplied from local funds. When these local sources are shown on the financial statement to be inadequate, we agree to supplement them at a rate not to exceed the normal ward rate but representing roughly the amount by which hospital resources are inadequate to meet hospital costs of free service divided by the number of days care given to free patients.

"This basis has been adopted because it represents, as nearly as we can compute it, the amount by which local resources are inadequate. It is purely a temporary expedient and, as the burden of free service drops and hospital resources expand, it can be withdrawn without interfering with the normal support of the hospital."

Hospitals desiring to receive these funds must file on approved forms applications and financial statements regarding the cost of care to the indigent sick. These statements are analyzed and a schedule of rates to be paid to the hospital is devised. Except in emergencies, payments will not be made for the care of patients unless their hospitalization is ordered by a physician and approved in advance by the local relief authorities. The per diem payment granted must cover all charges.

Medical relief policies in New Jersey have been defined by a medical advisory committee representing jointly the state medical society and the emergency relief administration. The most important of these policies are free choice of physician and hospital; remuneration of physician and hospital, in part at least, for service to the indigent sick; restriction of treatment of indigent sick to regularly licensed doctors of medicine and assumption by county medical societies of the responsibility for disciplining physicians when necessary by removal from the list of approved physicians.

Italy Plans Erection of New Hospitals

Plans have been approved for the completion and further erection in Italy between now and next spring of thirty-one new sanitary institutions with an aggregate bed capacity of 12,900, the expenditure for such work being estimated at 90,000,000 lire. The hospitals in question will be erected in many sections of the country.

NEWS OF THE MONTH

Michigan's Hospital Facilities Are Analyzed in Medical Society's Report

The report of the Committee on Survey of Medical Services and Health Agencies of the Michigan State Medical Society includes a statistical study of hospitals in that state.

"The conclusion may be drawn," says the committee's report, "that the number of general and special hospital beds in Michigan is not only above average for this area of the country but closely approaches the number required for the needs of the people. Concerning mental hospitals Michigan, with a ratio of one bed per 284 population in 1931, is somewhat below the average for the country and far below the actual needs of the population.

Too Few Tuberculosis Beds

"Tuberculosis hospital facilities are above the average for the country, one bed per 1,606 people in Michigan compared with one bed per 1,923 people in the United States. However, considering the needs—one bed to 703 people—Michigan has less than half the number of tuberculosis beds required for good medical care."

Not only does the report consider the total number of beds, but also the distribution of these beds throughout the state. "It must be concluded that certain areas of the state are provided with more beds than necessary for adequate general and special hospital care. In other areas, the number is entirely inadequate. This situation indicates strongly the need for regional planning in the location and development of hospitals. It also indicates that the public cannot and should not be expected to support all hospitals in an area or community unless there is some balance between the beds available and the beds needed."

The control of hospitals in Michigan is more centralized in governmental agencies than is the case in the country as a whole. Ninety-six per cent of the beds for nervous and mental patients and 83 per cent of the beds for tuberculous patients are controlled by governmental agencies. Even in the general and special hospitals, 54 per cent of the beds are under governmental control. Furthermore the occupancy rate of the government owned hospitals in 1931 was 67.4 per cent, while that in the nongovernmental hospitals was only 60.3 per cent. The number of days of care given by the governmental hospitals increased 8 per cent from 1929 to 1931, while the corresponding figure for nongovernmental hospitals decreased by 8.6 per cent. Not only did the number of days of care provided by the nongovernmental hospitals fall off but the percentage of patients who paid full rates dropped also. The latter figures were: 1929, 54.3 per cent; 1930, 48.9 per cent, and 1931, 45.9 per cent.

Hospital accounting procedures draw forth caustic comment from the committee. "The data dealing with hospital incomes and costs per patient day are of little value. There is one exception to this statement—the data are extremely valuable in that they show the pressing need for the adoption of some standards of accounting by hospital administrators. . . There are almost as many patterns for computing costs as there are hospitals. The result is a loss of comparative values in the cost data from different institutions. . . It is also obvious from the data supplied by the hospitals that too little is known about the actual costs and incomes from specific services in the different hospitals."

Many Forms of Social Insurance

The discussion of health insurance is particularly interesting. "It is apparent," the report states, "that the same causative factors that obtained in other countries and led to health insurance are operating in the United States. Many forms of social insurance are being widely considered and in some areas have been adopted. Health insurance plans are being discussed not only by medical organizations but by groups interested in its business and profit possibilities. It is the latter influence that frames a definite danger to medicine and the public.

"The committee views health insurance as a movement that makes possible a wider distribution of medical service and at the same time offers possibilities for the reduction of medical indigency."

Seek Opening of New York Hospital

A petition has been presented to Mayor O'Brien, New York City, by a group of civic interests to put the completion and opening of the Queensborough General Hospital on the city's preferred list of public projects requiring aid from the Reconstruction Finance Corporation. Four buildings of the hospital have not been opened because of a lack of funds for furnishings, equipment and maintenance.

Coming Meetings

American College of Surgeons.
President, Dr. J. Bentley Squier, New York City.
Director general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, Chicago, October 9-13.

American Dietetic Association.
President, Dr. Kate Daum, University of Iowa Hospital, Iowa City, Iowa.
Business manager, Dorothy I. Lenfest, 185 North Wabash Avenue, Chicago.
Next meeting, Chicago, October 9-12.

American Hospital Association.
President, Dr. George F. Stephens, Winnipeg General Hospital, Winnipeg, Man.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, Milwaukee, September 11-15.

American Occupational Therapy Association.
President, Dr. Joseph C. Doane, Jewish Hospital, Philadelphia.
Secretary-treasurer, Eleanor Clarke Slagle, New York City.
Next meeting, Milwaukee, September 11-13.

American Protestant Hospital Association.
President, Rev. Thomas A. Hyde, Christ Hospital, Jersey City, N. J.
Executive secretary, Dr. Frank C. English, 3233 Griest Avenue, Cincinnati.
Next meeting, Milwaukee, September 8-11.

American Public Health Association.
President, Dr. John A. Ferrell, New York City.
Acting executive secretary, Dr. Kendall Emerson, 450 Seventh Avenue, New York City.
Next meeting, Indianapolis, October 9-12.

Association of Record Librarians of North America.
President, Alice G. Kirkland, Samuel Merritt Hospital, Oakland, Calif.
Secretary, Marjorie Boulton, Jewish Hospital, St. Louis.
Next meeting, Chicago, October 9-13.

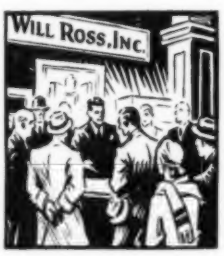
Canadian Hospital Council.
Next meeting, Winnipeg, September 8-9.

A LIFE OF SERVICE » » » IN THREE YEARS

SOMEDAY, an inspired historian, startled into attention, will pause over his records, and from dry statistics will write a saga around those who served so faithfully in the hospitals, large and small, during the past three and a half dark years.

Before his eyes will rise the vision of an army of men and women on the verge of penury themselves, carrying on bravely in institutions with little or no income, facing an uncertain future with open eyes and calmly meeting unprecedented demands with all they had to give—their time and energy and faith.

Out of the past, heroic figures—individuals. Out of the present, a countless host of figures—a heroic throng. So have the traditions of Medicine and Nursing been upheld.



We'll be looking for you at the
MILWAUKEE CONVENTION
Booths 248-49-50-51

We have been with you all through the battle of the budgets. When your bankers lost their faith, we drove our bankers to despair by extending further credit. We have laughed with you over the impending cataclysm and with you have damned a social structure that could make such conditions possible. And because we knew your needs, we have maintained a full force of workers to be ready to give you prompt, intelligent service; we have kept up our stocks in both quantity and quality to be ready to meet your emergency demands. For we felt that we too were a part of the hospital group and that upon us also rested a real obligation for service.

So we are proud to have had some part in this epic. And now we are still able to go forward with you with service facilities in personnel and merchandise unimpaired and still dependable.

WILL ROSS, Inc., Wholesale Hospital Supplies
779-783 N. Water Street Milwaukee, Wisconsin

PERSONALS

DR. L. J. MOORMAN has succeeded DR. J. B. SMITH as administrative officer, University Hospital, Oklahoma City, Okla.

C. C. HAWKINS was recently appointed superintendent, Jefferson Davis Hospital, Houston, Tex.

MARGARET E. KENNEDY has been named acting superintendent, Paris Sanitarium, Paris, Tex.

DR. J. L. MCELROY, superintendent, Medical College of Virginia Hospitals, Richmond, Va., has been named medical director, American Hospital, Paris, France. He will be succeeded by DR. LEWIS E. JARRETT, formerly assistant superintendent.

MARY L. WHITNEY has resigned as superintendent, Mercy Hospital, Altoona, Pa.

THERESA NORBERG resigned recently as superintendent, Community Hospital, Beloit, Kan.

DOROTHY MCMASTERS is the new superintendent, William Newton Memorial Hospital, Winfield, Kan., succeeding VIOLET S. SOCHECK.

DR. WILLIS E. MERRIMAN has been appointed superintendent, Manhattan State Hospital, New York City, succeeding the late DR. I. J. FURMAN. Since 1908, DOCTOR MERRIMAN has been identified with the staff of Hudson River State Hospital, Poughkeepsie, N. Y.

DR. BARNET LEMCHEN, formerly assistant managing officer, has been named acting managing officer, Chicago State Hospital, Dunning, Ill. DOCTOR LEMCHEN has been a member of the hospital's staff since 1912.

HAZEL I. CAVE, formerly superintendent of nurses, New York Infirmary for Women and Children, New York City, has been named superintendent, Orillia Soldiers' Memorial Hospital, Orillia, Ont., Can.

DR. J. G. WILLIAM GREEFF, commissioner of hospitals, New York City, resigned from that position on August 15. DOCTOR GREEFF was commissioner for the last three and a half years, having entered the department on December 30, 1929.

SIDNEY G. DAVIDSON, who for a number of years has been superintendent, Butterworth Hospital, Grand Rapids, Mich., has accepted the position of superintendent, Grace Hospital, New Haven, Conn. MR. DAVIDSON will assume his new duties on the first of September.

JOHN H. PARKER has been named business manager and DR. C. ARKEBAUER, chief of medical staff, State Hospital (formerly State Hospital for Nervous Diseases), Little Rock, Ark. The hospital now has a dual management.

ALVERNA SEE has been appointed superintendent, Burnham City Hospital, Champaign, Ill.

OMA KULL was appointed August 15 superintendent, Marietta Phelps Hospital, Macomb, Ill.

CHARLES LEE was recently named superintendent, Homeopathic Hospital, East Orange, N. J.

ELIZABETH WILLIAMS has been named superintendent, Sarasota Hospital, Sarasota, Fla.

DR. R. A. GOODNER has been named to succeed Dr. Oscar J. Hagebush as superintendent, Anna State Hospital, Anna, Ill.

C. GAPINSKI has resigned as superintendent, Sartori Memorial Hospital, Cedar Falls, Iowa, effective September 1. AMY D. AADALEN, superintendent, Savanna Public Hospital, Savanna, Ill., has been appointed superintendent, Sartori Memorial Hospital.

Hospital Movie Is Shown to Public for First Time

"Good Hospital Care," a talking motion picture prepared by the American College of Surgeons, was given its premier public showing on August 18 at the John B. Murphy Memorial Auditorium of the college in Chicago. The "talkie" brought its fascinating tale of the procedures necessary for the provision of modern medical service to a large and responsive audience.

The film, unlike many "educational" films, is presented in a lively way that immediately captures the interest of the audience. It opens with a series of automobile crashes, with victims being rushed to the hospital. Following the opening scenes, an introductory talk explaining hospital standardization is made by Dr. Franklin H. Martin, director general of the college. His talk is illustrated by pictures.

The actual care of patients is then pictured with simple and graphic commentaries by Dr. Malcolm T. MacEachern, director of hospital activities. More than sixty persons are in the cast of the picture. It was produced at St. Joseph Mercy Hospital, Aurora, Ill., with funds provided by a special grant from the Petrolagar Laboratories.

At its premier showing addresses were made by Dr. Franklin H. Martin, Dr. Bert W. Caldwell, Dr. Austin A. Hayden, president, Chicago Medical Society, Paul H. Fesler, president, Chicago Hospital Association, Dr. Charles H. Mayo, regent of the college, and Dr. George W. Crile, chairman of the board of regents of the college of surgeons.

The film is available for showings before institutional, medical and lay groups. It is of two reels on noninflammable film.

Faithful Employee of Baltimore Hospital Dies

On a mantel in the office of the director of the Johns Hopkins Hospital, Baltimore, stands a small glass case. In the case are a key and a photograph.

One day in May, 1889, that key unlocked the doors of the hospital to receive its first patients. The photograph is of the man who wielded the key. His name was William Woods. He had been employed as a carpenter in the construction of the hospital and following the completion of the original plant he became the master carpenter of the institution, which position he held uninterruptedly until August 5, 1933, on which date he died at the age of eighty-two.

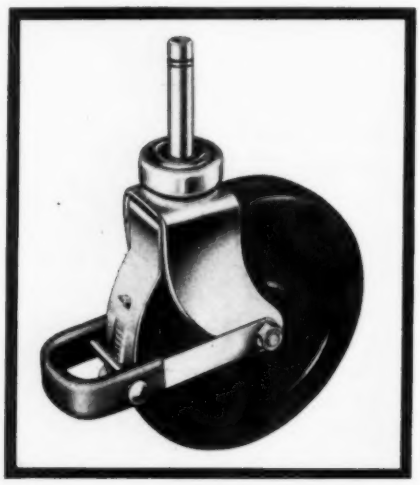
Mr. Woods enjoyed the friendship of such men as Osler and Halsted and others who wrote their names so indelibly into the hospital's early history.

NEWS FROM MANUFACTURERS

A CASTER EQUIPPED WITH NEW BRAKE

The Bassick Company, Bridgeport, Conn., has announced a new line of casters and floor protection equipment for institution use.

The accompanying photograph shows the Bassick double action ball bearing caster equipped with a new type of caster wheel brake. Features of this new brake are its simple and positive action and economical construction. The braking action is applied on the tread of the wheel over a large area, where the mechanical advantage is greatest and surest and where there can be no damage to the wheel. The nonmarking rubber covering on the brake lever also



serves as a bumper, preventing damage to and marks on the walls. Various types of institutional equipment casters with 3-inch, 4-inch and 5-inch diameter wheels are available with this new brake.

SQUIBB EXPANDS HOSPITAL SERVICE

E. R. Squibb & Sons have inaugurated a hospital department to extend an even greater service to hospitals than has been done in the past.

The department is under the management of S. H. Conover, who is in complete charge of the service. Mr. Conover has been affiliated with the company for twenty-five years, and during this time has visited hundreds of hospitals and represented Squibb at all hospital conventions.

STAINLESS ALUMINUM UTENSILS

A new electrolytic treatment, known as anodizing, has been given to the aluminum utensils for hospital use that are made by the Aluminum Cooking Utensil Co., New Kensington, Pa. This treatment gives a hard, even surface with a satin-like finish which will not stain either the linen or clothing.

Utensils for the operating room and for ward and private rooms have been developed so that a complete "Wear-Ever" service of anodized aluminum may be obtained. Hard sheet aluminum that is light and seamless has been used in all this equipment.

For the operating room there are solution basins, solution pitchers of 1½, 2⅜ and 3¼-quart sizes, four sizes of instrument sterilizing trays, one with a fitted cover, and a ten-quart dressing pail. For room service a selection may be made from the two-quart bedside pitcher without cover, or a similar pitcher with a nondrip lid that is suitable for table use, a drinking cup, a rectangular tray, a griddle cake cover, a thermo service cover, wash basins and custard cups.

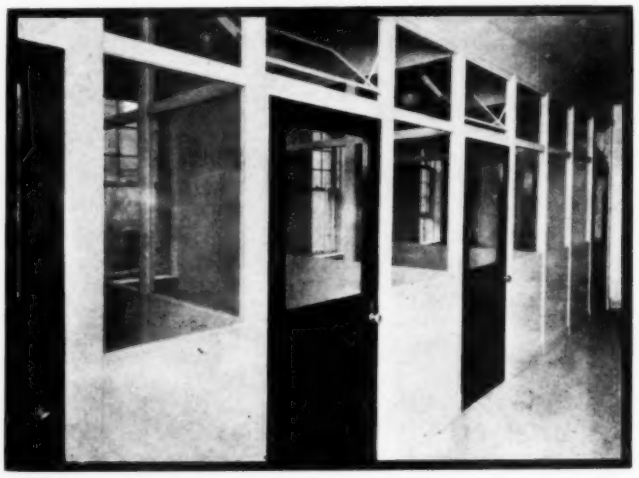
Two other developments for hospital use are an ice crusher that crushes ice cakes to "pack" size by merely depressing a lever handle, and a steam jacketed kettle for diet kitchens. The kettle is a ten-quart size that cooks foods quickly and empties easily.

NEW TYPE OF METAL PARTITIONS

The metal partitions recently developed by The Mills Company, Cleveland, have members that are rigidly interlocked by a new sewing process. The sewing may be done at the hospital, either on a machine or with a hand tool. Pressure is exerted which causes a series of indentations on both pieces of steel that are to be joined, interlocking the two in such a manner that they become practically one unit. If redesign or a change of size is necessary, the material may be ripped apart at the hospital and resewed with a simple hand tool.

The partitions may be obtained in a variety of designs to make flush walls of steel, paneled steel walls or combinations of glass and steel for borrowed lights and transoms. Either single sheet ⅜-inch partitions, 1¾-inch insulated panels or 4-inch partitions may be selected.

The method of making connections is important both in the matter of assembly and in removing for reassembly



in a changed partition arrangement. The floor connections of the partition are universal for straightaways, corners, three-way and four-way runs and door jambs. It is not necessary to know the location of the door, the corner or the three-way run when making a layout. The clips that join the post members of the panel are designed as truss members to prevent weaving of the post, and they are not attached to the face of the post by metal distortion. This makes it possible to place a post clip at any point in the vertical distance of the post. The post clip is also universal for straightaways, three-way runs and corners.

The plinth block hooks on over the base to hold it firmly in place. The cornice trim snaps on continuously to an internal cornice reenforcement to ensure a close fitting cornice trim.

The Syncro-Fit method of assembly makes it possible for the hospital to obtain at low cost the exact type of partition installation desired.

AMERICAN STERILIZER CO. EXPANDS SERVICE

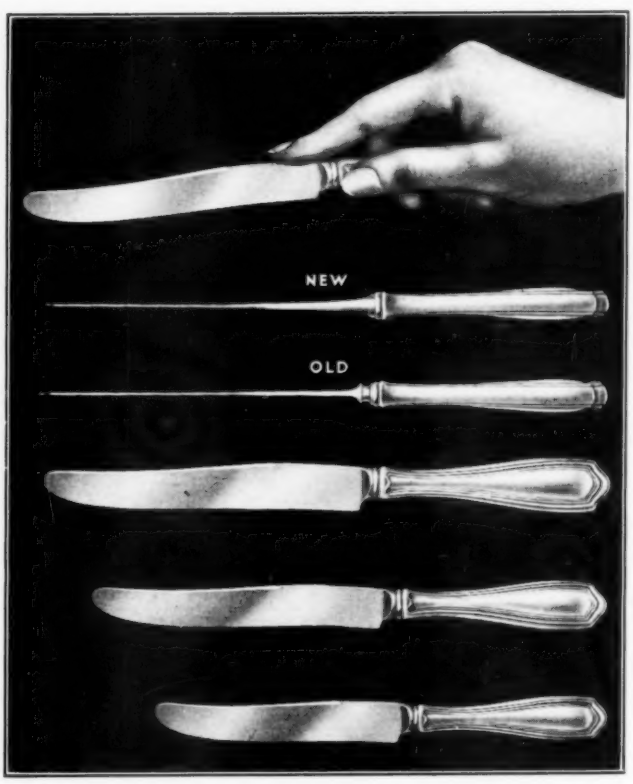
The American Sterilizer Company, Erie, Pa., has purchased the sterilizer, disinfector, still, warming cabinet, operating table, fracture table and autopsy table departments of the Kny-Scheerer Corporation.

The company will build the Kny-Scheerer line of operating tables, Hawley fracture tables and Martland autopsy tables. In addition, the complete stock of spare parts will be taken over so that all operating tables and sterilizing equipment now in use will be serviced by the American Sterilizer Company.

Customers in the vicinity of New York requiring service should communicate with this company at 200 Fifth Avenue, New York City. All others should address the factory at Erie, Pa.

A NEW "BAYONET" SHAPE BLADE

A new shape blade which the Gorham Company, 6 West 48th Street, New York City, calls the "Bayonet" possesses the distinctive advantage of enabling the patient to cut his food with greater ease. This is due to the wide back, which is three times as thick as the old style blade at this



point. This makes it possible to rest the index finger firmly on the back of the blade. The blade is ground down extra thin on the cutting edge.

The Gorham Company is offering this new blade for three sizes of knives with single bolster and it may be had in any of the Gorham hospital patterns.

AN AUTOMATIC SPRAY DISHWASHER

The Kraeft Dishwasher, made by the Kraeft Dishwasher Company, Erie, Pa., is an all automatic spray type machine which occupies a floor space of six square feet. The washing and rinsing operations are controlled by the rack in which the tableware is stacked for washing. The operator is not required to touch the machine from the time it is

started until the work is completed. In design, simplicity is the governing factor to make cleaning easy and operation efficient. Sanitary features have been incorporated into the mechanism so that a minimum of time is spent in maintenance.

The machine is recommended for nurses' homes and hospitals with 50 to 150 beds. The machine is available in stainless steel and enameled steel finishes.

AN INFANT'S FOOTPRINT OUTFIT

A compact and dependable outfit for taking infant footprints is being offered by the Flak Finger Print System Co., 1 Liberty Street, New York City. One of the outstanding features of this equipment is that the prints may be handled at once, drying automatically in a few minutes. Another point is the nonsoiling ink brayer that permits the roller to be put down anywhere with no danger of soiling

the case, table or papers. The fact that the entire layout is packed in a small, substantial walnut case with a reversible cover adds considerably to the convenience with which it is handled.

With the brayer come a special composition finger print roller for uniform inking of infants' foot soles, a tube of special finger print ink sufficient for over 200 sets of prints, an extra tube of ink in a fiber case with a screw cap for storage and emergency use, an ink plate of solid nickel for perfect distribution of ink and taking mothers' finger

prints, a rocker for taking footprints on slips of special paper, a sprinkler bottle of special cleanser which applied to the roller and ink plate weekly makes it possible to keep the outfit in perfect condition at all times, six lint-free finger print towels and also a reserve package of six towels, and a fine quality of 2½-inch imported finger print reading glass with a nickel frame and wooden handle.

Simple directions are enclosed for taking and comparing prints and keeping the outfit in perfect condition. The company also offers free examination of practice prints returned with corrections and also free professional opinion in doubtful cases.

NEW TRADE CATALOGUES AND PAMPHLETS

Will Ross Mfg. Co.—New garments, linens and blankets of the White Knight line feature a recent publication of Will Ross Mfg. Co., 779 N. Water Street, Milwaukee. Professional and service uniforms and accessories are illustrated and described in detail, and one page of this attractive catalogue is devoted to binders, caps and accessories.

The Burdick Corporation—A new electrosurgical unit for cases where electrosurgery is indicated is offered in a sheet published by The Burdick Corporation, Milton, Wis. Readily portable, the unit is completely equipped to cover full selection of current for all tissue dissection and coagulation.

Waters-Genter Company—"The New Toastmaster With the Revolutionary Flexible Clock" is the title of an illustrated circular from the Waters-Genter Company, Minneapolis. Quantity toast production is achieved with the new four-slice toaster, while the two-slice toaster, a small but heavy duty type, is designed particularly for the hospital diet kitchen.

Nash Engineering Co.—A thirty-five-page catalogue containing general information and engineering data on pumps is some recent literature from the Nash Engineering Company, South Norwalk, Conn. Information about Hytor vacuum pumps and compressors, Jennings return line vacuum heating pumps, vapor turbine vacuum heating pumps, condensation pumps, centrifugal and suction pumps, and sump and sewage pumps and ejectors is contained in this booklet. The construction and operation of many of these items are explained.

B. F. Sturtevant Co.—Catalogue No. 392, covering its line of air conditioning equipment, has just been issued by the B. F. Sturtevant Company, Hyde Park, Boston, Mass. The booklet contains information on unit air conditioners, and humidifiers, speed heaters and coolers, filticoolers and suspended air conditioning units.

McLeod and Henry Co.—A sixteen-page bulletin describing its new "Steel Mixture" oil brand firebrick for oil-fired furnaces, Carbex silicon-carbide brick for boiler, stoker and industrial furnace linings, high temperature fire cements, and furnace linings and arches has been published by McLeod and Henry Co., Troy, N. Y. This bulletin, No. F-94, contains information on the selection and care of firebrick furnace linings.

American Sterilizer Co.—The use of direct steam for the dressing sterilizer has been made possible by the introduction of an automatic pressure control valve. One valve replaces the four valves that were necessary to control the older type of boiler. Present equipment may be changed easily and at a small cost, according to the American Sterilizer Co., Erie, Pa. A pamphlet explaining in detail how this modernization is accomplished may be obtained from the company.